COGNITIVE BEHAVIOUR THERAPY VERSUS TREATMENT AS USUAL IN THE TREATMENT OF DEPRESSION IN OLDER PEOPLE.

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List of Appendices

APPENDIX ONE:

PUBLICATIONS ARISING FROM THESIS

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Invited Essay

An Empirical Review of Cognitive Therapy for Late Life Depression: Does Research Evidence Suggest Adaptations are Necessary for Cognitive Therapy with Older Adults?

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This paper describes the treatment of depression in older adults using cognitive behaviour therapy (CBT) as first developed by Beck and colleagues. Evidence for the validity and effectiveness of this form of treatment is considered by reference to published outcome research and meta-analysis studies. Attempts to compare CBT approaches with other forms of psychotherapy have indicated minimal differences in outcome with all therapy modalities reporting beneficial effects in comparison to no treatment or placebo. It is clear that an empirical evaluation of cognitive-behaviour therapy for late life depression is still in its early stages as evidenced by the small number of published studies. The clinical issue of whether therapeutic adaptations are necessary in order for cognitive therapy to be effective with older adults is briefly discussed with reference to the literature from outcome research. **Copyright © 2001 John Wiley & Sons, Ltd.**

SETTING THE CONTEXT: PREVALENCE, UNDER-DETECTION AND UNDER-TREATMENT OF DEPRESSION IN OLDER ADULTS

Depressive symptoms and depressive disorders are a substantial mental health problem for older adults (see Blazer *et al.*, 1987; Zarit and Zarit, 1998). While it is generally acknowledged that depression is the most commmon psychiatric disorder amongst older adults, with Livingston *et al.* (1990), identifying a prevalence rate of 16% depression in their inner London sample, and Copeland *et al.* (1987) reporting similar rates for

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their community sample, rates of major depressive disorder amongst older people are not more frequent when compared to other age groups (Futterman *et al.*, 1995). Prognosis for depression in older adults is generally considered to be somewhat mixed (Ames and Allen, 1991) with greater age (70+ years) resulting in increased risk of relapse and recurrence (Reynolds *et al.*, 1999a, b). In recent USA studies such as the epidemiological catchment area study prevalence rates for depression were lowest in the over-65s age grouping (for review see Kaelber *et al.*, 1995). Henderson (1994) points out that under-representation of physically ill and frail subjects may have reduced prevalence rates.

Depression in later life appears to have an impact on life expectancy, leading to an increased risk of mortality which may not be completely accounted for by physical ill-health (Ames and Allen, 1991) or by suicide (Burvill and Hall, 1994).

It does not necessarily follow that when depression *is* identified by GPs that older people will be offered treatment. McDonald (1986) indicates that although GPs are good at identifying depressive symptoms, in very few cases this resulted in treatment being offered by GPs themselves or resulted in referral to other agencies. Crawford *et al.* (1998) report that GPs are aware of depression in a little over one-half of their patients aged 65 years and above, but that men living alone, those with least education and those with visual impairment were much less likely to be identified as depressed by GPs. As with McDonald's results, levels of active treatment were very low with the majority of older people receiving little to no treatment for their depression. Of those patients receiving treatment this consisted mainly of antidepressant treatment. Levels of psychological intervention were very low. Orrell *et al.* (1995) in a survey of the prescription practices of GPs across the UK noted that in many cases subtherapeutic dosages were being prescribed for the treatment of depression in older adults.

It is often presumed that depression is a natural consequence of the losses experienced by this population in terms of emotional attachments, physical independence and socioeconomic hardships. The 'understandability phenomenon' (Blanchard, 1996) or the 'fallacy of good reasons' (Unutzer *et al.*, 1999) is the notion that depression in older people is in some way to be expected and is a normal part of ageing. Assumptions such as these can influence expectations of client, therapist and physician alike resulting in a sense of hopelessness about treatment (Unutzer *et al.*, 1999). Seeing depression as understandable produces therapeutic nihilism and lowers expectations for treatment success. In a naturalistic survey of older in-patients receiving treatment for depression, Heeren *et al.* (1997) demonstrated that a combination of low expectation of treatment success and a fear of possible negative effects from antidepressant medication led to a high incidence of prescriptions of subtherapeutic dosages of antidepressant medications. As older people have high rates of physical illness and frailty, and are very often taking many other non-psychotropic medications, a fear of side-effects from antidepressant medications, such as cardiac arrhythmias (Ryynanen, 1993) or increased levels of confusion and disorientation (Katz & Streim, 1994) may influence practitioners' decisions regarding use of medications even in cases where treatment is clearly indicated (Evans, 1995). Polypharmacy of non-psychotropic medications and a fear of addiction to medication may also result in a unwillingness on the part of older adults to take antidepressant medication (Unutzer *et al.*, 1999). Even in circumstances, where active pharmacological treatment is low, referrals of older adults for psychological treatment for late life depression are not necessarily considered.

As well as the understandability phenomenon, there are a number of other reasons why older people do not receive psychological treatment for depression such as, pessimism regarding the relevance and usefulness of psychotherapy with older people, lack of training of professionals and therapists in geriatric/gerontological psychiatry and the legacy of Freud's assertion (Lovestone, 1983) that older people lack the mental plasticity to change or to benefit from psychotherapy. Ageism may also be a factor, Woods (1995) states that service providers have tended to neglect this group of patients with the result that older adults are unfamiliar with psychological treatments and have an expectation of receiving physical treatments for a range of psychological difficulties. Currently if an older adult does receive specialist treatment for depression then the likelihood is that pharmacotherapy is offered in the first instance with electroconvulsive therapy (ECT) also being offered. In 1991, The National Institute of Health (NIH) (1991) consensus statement on the treatment of late life depression recommend psychological treatments for depression in older adults only after pharmacotherapy and ECT had been tried first. The NIH panel concluded that psychotherapy was only moderately effective from a review of three studies NIH, 1991; Zeiss and Breckenridge, 1997). Thus given the foregoing

where older adults are not being referred for potentially effective treatment for depression, the efficacy of non-pharmacological treatment alternatives for depression in older adults needs to be urgently established.

COGNITIVE BEHAVIOUR THERAPY FOR OLDER ADULTS

Cognitive-Behaviour therapy (CBT) is an active, directive time-limited and structured treatment approach. The most common form of CBT used in the UK is based upon the cognitive model of dysfunctional information processing in emotional disorders developed by Aaron T. Beck and colleagues (Beck *et al.*, 1979). In the Beck model, cognitions (which can be thoughts or images) are associated with, and in part determined by, underlying beliefs, attitudes and assumptions. The most basic premise of CBT is, how a person feels and behaves determines the way that person thinks and makes sense of their experiences. This premise has historical roots in the writings of Greek philosophers such as Epictetus who wrote, 'Men are disturbed not by things, but by the views which they take of them'.

CBT can be differentiated from other forms of psychotherapy by its emphasis on the empirical investigation of the patient's thoughts, appraisals, inferences and assumptions. CBT involves engaging the client in a process of discovery where they identify their thoughts as ideas or hypotheses to be tested and not as beliefs that are fixed, valid and immutable. This aim is achieved through the explicit use of cognitive and behavioural techniques such as activity scheduling, graded task assignments, problem solving techniques, thought identification and monitoring, and examining and challenging core beliefs about the self, world and future. CBT is problem oriented and its focus upon the symptoms of depression e.g. inertia, hopelessness and pessimism especially in regard to health related matters, makes this approach particularly relevant for late life depression (Steuer and Hammen, 1983; Morris and Morris, 1991). The terms cognitive therapy and cognitive behaviour therapy are used interchangeably in this paper.

EFFICACY OF COGNITIVE THERAPY FOR DEPRESSION IN OLDER ADULTS (META-ANALYSES)

Reviews of outcome research into psychological treatment approaches for depression in older adults have generally suggested that CBT is an effective therapeutic approach (Futterman *et al.*, 1995; Gardner, 1996; Dick *et al.*, 1996; Woods and Roth, 1996; Laidlaw, 1997). The purpose of this present review is to bring together, for the first time in a single source, information about meta-analyses of psychotherapy with older adults (see Table 1) and individual outcome research (see Table 2) of cognitive therapy with depressed older adults. In addition, the present review discusses whether evidence from research suggests that cognitive therapy requires to be adapted in order for it to be effective with older adults.

In a meta-analytic review of the effect of psychosocial treatments for late life depression Scogin and McElreath (1994) note that effect sizes for treatment versus no treatment or placebo were substantial and were very similar to effect sizes calculated by Robinson *et al.* (1990) in their review of psychotherapy for depression across all age ranges. Despite the clear superiority of psychological treatments versus no treatment, the data did not suggest the superiority of any single treatment modality. Cross comparisons investigating differences in efficacy between brief forms of psychotherapy suggest that many treatments appear equally successful in treating late life depression (Scogin and McElreath, 1994).

Scogin and McElreath (1994) have been criticized for defining cognitive therapy too broadly when it came to looking at the efficacy of different treatment modalities (Koder *et al.*, 1996). Certainly Scogin and McElreath (1994) included personal construct therapy, self-administered bibliotherapy, and behaviour therapy within their definition of cognitive therapy. In addition their overall meta-analyses were too broad and overinclusive. There seems little merit in combining apparently markedly different treatments (psychodynamic psychotherapy and behaviour therapy) together to derive a single measure of effect. More information is lost than is gained by such an approach. Overall, the review by Scogin and McElreath (1994) ought to be interpreted with caution.

In the most specific review looking at outcome research into strictly defined cognitive therapy for the treatment of depression in older adults, Koder *et al.* (1996) were able to identify only seven treatment comparison studies over the period 1981 to 1994. Three of these seven studies favoured CT over other treatment modalities, three failed to find significant treatment differences between modalities and one study was positive for some aspects of cognitive treatment. In this meta-analysis

Table 1. Summary of meta-analyses studies

Authors	Years reviewed	No. of studies in analyses	Effect sizes	Conclusions
Scogin and McElreath (1994)	1970–1988	17 broad categorization of treatments	Overall effect size for treatment versus no-treatment or placebo is 0.78	No clear superiority for any system of psychotherapy in the treatment of geriatric depression
Koder *et al.* (1996)	1981–1994	Seven all CT studies	CT vs BT mean effect size is 0.26 CT vs PP mean effect size is 0.41 CT to WL mean effect size is 1.22	Too few studies of sufficient scientific and methodological merit upon which a definitive conclusion can be reached about the relative efficacy of CT over other treatments but CT is undoubtedly an effective treatment option for late life depression
Engels and Verney (1997)	1974–1992	17 studies–all patients carry diagnosis of MDD	Mean effect size of 0.63 (i.e client was on average 74% better off than non-treated controls)	Individual treatment more effective than group methods of treatment for depression in older people. Cognitive and behavioural treatments produce largest effects
Cuijpers (1998)	1981–1994	14 psychological treatments	Effect size of 0.77 comparable to that found in younger samples	'Effects of interventions in which the depressed elderly are actively recruited from the community are large. These effects are comparable to the effects of psychotherapy of depression in younger age groups'
Gerson *et al.* (1999)	1974–1998	45 (four non-drug) 28 (two non-drug)	Drug and non-drug treatments appear equally efficacious. No difference in results if use stricter criteria for studies	'Effective psychological interventions constitute a much-needed addition to antidepressant medication for depressed older patients'
Robinson *et al.* (1999)*	1976–1986	58 studies	Overall effect size for treatment versus no-treatment is 0.73.	All forms of psychotherapy more effective than no treatment. Differences in efficacy of psychotherapies disappear when take therapist allegiance into account

CT, cognitive therapy; BT, behaviour therapy; PP, psychodynamic psychotherapy. NB. Cohen (1992) recommends that for the behavioural sciences, effect size of 0.8 is large, 0.5 is moderate, 0.2 is small.
*For comparison of outcome between age groups.

Table 2. Features of outcome studies using CBT for late life depression

Authors	Treatment conditions	N	Mean age	Length of Tx (weeks)	Drop-out (%)	Format	HRSD Pre	HRSD Post	Effect size*	BDI Pre	BDI Post	Effect size*
Gallagher and	Cognitive	10	68.3	16 sessions	10[a]	Individual	17.5	8.2	0.87§	23.6	9.7	1.03§
Thompson (1982)	Behavioural	10	66.0	over 12 weeks	50[a]		18.9	8.5	4.50§	29.2	12.6	2.75§
Gallagher and Thompson (1983)	Insight-Orient	10	69.0		20[a]		18.6	11.8		25.2	14.3	
Jarvik *et al.* (1982)	Cognitive	16	66[c]	46 sessions	39	Group	18.6	10.1	1.70	16.4	8.6	1.40
Steuer *et al.* (1984)	psychodynamic	17	66[c]	over 9 months	39		20.5	11.2	1.80	15.4	12.2	0.48
Beutler *et al.* (1987)	CT + Medic†	13	71.2	20 weeks	31 CBT	Group	21.3	14.7	1.54	11.4	9.6	0.29
	CT + Placebo	16	(F)		67 medic		21.6	14.3	1.18	12.0	7.0	0.95
	Medication	12	70.2				22.5	14.3	1.69	9.8	8.3	0.36
	Placebo†	15	(M)				22.8	16.8	1.01	11.7	9.9	0.30
Thompson *et al.* (1987)	Cognitive	27	66.1	16 to 20 weekly	27	Individual	19.2	10.5	1.42	25.3	13.6	1.34
	Behavioural	25	66.9	sessions	14		19.3	8.9	1.78	22.5	12.4	1.33
	Insight-oriented	24	66.7		14		19.0	10.0	1.82	23.4	14.2	1.30
	Delayed control	19	67.6		n/a		18.3	17.9	0.08	21.1	22.5	0.17
Leung and Orrell (1992)	Cognitive	27	70.4	7 weekly sessions	0.0	Group	—	—	—	21.5	16.3	0.51
Arean *et al.* (1993)	Problem solving	19	67.0	12 weekly sessions	33	Group	25.2	8.8	2.60	23.7	15.7	1.25
	Reminiscence	28	66.7		20		25.3	17.6	0.91	23.6	16.9	0.79
	Wait list	20	65.5		n/a		22.4	22.0	0.08	23.0	21.2	0.32
Gallagher-Thompson	Cognitive	36	62.0[b]	20 sessions	14	Individual	—	48	0.55	—	46	0.88
and Steffen (1994)	Insight-oriented	30			30		—			—		
Rokke *et al.* (2000)	Self-mgmt‡	9	67.2[b]	10 weekly	25	Group	15.3	8.0	1.73	19.0	9.6	1.43
	Education	9		sessions	10		16.4	10.1	0.93	16.9	9.8	1.06
	Wait list	16			11		14.7	10.7	0.79	18.1	15.1	0.46

[a] In total eight patients dropped out of treatment within the first 4 weeks and were replaced.
[b] Mean for sample as whole reported.
[c] Median only reported for both groups as a whole.
* Calculation of effect sizes for within treatment effects. The mean score for pre and post treatment scores on measures (BDI and HRSD) are subtracted and divided by the pooled standard deviation. Hunter and Schimdt (1990) provide a calculation to correct for small sample size bias. Generally this formula is applied where $n < 20$, but it is applied throughout in calculation of effect sizes in Table 2.
† Alprazolam.
‡ Self management is based upon the cognitive therapy model of Rehm.
§ Comparison of effect sizes when treatment is split according to endogenous/nonendogenous dichotomy. Larger effect sizes evident in treatment of non-endogenous depression.
Percentage of carers showing clinically significant change over course of treatment, note, treatment groups did not differ significantly, *t*-test data used in calculation of effect sizes.

there was an unfortunate error in that Koder *et al.* (1996) counted the studies by Jarvik *et al.* (1982) and Steuer *et al.* (1984) as separate studies whereas Jarvik *et al.* (1982) reported interim results and Steuer *et al.* (1984) reported the final analysis (Jarvik *et al.*, 1997).

Notwithstanding the error in their analysis, these authors correctly conclude on the basis of their analyses that there are too few studies of sufficient scientific and methodological merit upon which a definitive conclusion can be reached about the relative efficacy of cognitive therapy over other treatment modalities but it is undoubtedly an effective treatment procedure for late life depression. Without doubt overlap and imprecision regarding the definition between therapies limits comparisons at this stage (Koder *et al.*, 1996).

Engels and Verney (1997) reviewed 17 studies carried out between 1974 to 1992 investigating the effectiveness of psychological treatments for depression in older people. The mean effect size calculated in this meta-analysis was 0.63, although lower than other reported effect sizes it still showed that the mean person receiving treatment was better off than 74% of people not receiving treatment. Cognitive therapy and behavioural therapy were most effective as these treatments produced the largest effect sizes. A surprising result showing that combined cognitive and behavioural therapy (CBT) was less effective than either treatment alone may be explained in part by a narrow inclusive criteria for CBT by Engels and Verney (1997) and also by the small number of studies with heterogenous effect sizes. Studies characterized as purely cognitive such as those by Gallagher-Thompson and colleagues are probably more accurately described as cognitive-behavioural. Gallagher-Thompson and Thompson generally prefer the term CBT in preference to CT as they feel this is more reflective of their therapy approach (D. Gallagher-Thompson and L. W. Thompson, personal communication).

Engels and Verney (1997) also provide evidence for increased efficacy of individual rather than group therapy in older adults. This would appear to be particularly so for cognitive and behavioural treatments. Overall in this meta-analysis, psychotherapy with older adults appears to be most efficacious when the diagnosis is major depression or depression rather than multiple complaints. A possible difficulty in this conclusion is that information about achievement of diagnoses was often unclear in a number of studies. The authors also find an interesting possible age effect in that 'younger' older adults appear to benefit more from psychotherapy than the oldest age group patients. Engels and Verney (1997) urge caution over this finding but raise the issue of whether adaptations to therapy might benefit the oldest patients more. This issue will be further discussed below in this current review.

Cuijpers (1998) carried out a meta-analysis of the effectiveness of what he termed psychological outreach programmes for depression in older people. The review included a number of studies included in the previous analyses by Scogin and McElreath (1994), Koder *et al.* (1996), and Engels and Verney (1997). In all, Cuijpers (1998) included 14 studies in his meta-analysis. Cuijpers (1998) included studies if they were considered to be what he defined as outreach studies offering treatment to older people resident in the community. This included all research studies which actively sought to recruit subjects through radio, television and local community adverts. Cuijpers (1998) noted that the overall effect size of the psychological treatments for late life depression were large and similar to effect sizes quoted by Robinson *et al.* (1990) and Scogin and McElreath (1994).

Cuijpers (1998) calculated the overall attrition rate for psychological treatments for late llife depression as being 23%. Group treatment, cognitive and behavioural treatments, greater frequency of treatment sessions and being female all appeared to predict drop-out rates. However a number of limitations were again identified with the Cuijpers (1998) meta-analysis and these are very similar to those levelled at Scogin and McElreath (1994), i.e. broad range of treatments aggregated together, broad range of severity of depression, range of expertise evident in those providing psychological treatments. In addition, there seems little which has been added by Cuijpers' (1998) analyses. The rationale for aggregating studies simply because they were assumed to be active outreach programmes is weak.

Gerson *et al.* (1999) reviewed 45 studies carried out between 1974 to 1998 investigating the effectiveness of pharmacological and psychological treatments for depression in older people. Four studies used non-drug (psychological) methods of treatment for depression in later life. In their meta-analyses Gerson *et al.* (1999) only included studies if patients were diagnosed with major depressive disorder. Gerson *et al.* (1999) also utilized a stricter inclusion criteria such as: a minimum of 15 patients in each treatment group, description of dose regime

in both treatment and control groups, documentation of side-effects by self-report or questionnaire, specification of attrition rates and lastly statistical evaluation. Using this stricter criteria studies entered into the meta-analysis reduced to 28, two of which used psychological methods of treatment. The results of Gerson *et al.*'s meta-analyses were identical using either criteria (inclusive versus strict). Pharmacological and psychological treatments appear equally efficacious. There were no significant differences in the relative reduction on quantative measures of mood between treatments. Analyses also revealed no significant difference in attrition rates between pharmacological and psychological treatments. Gerson *et al.* (1999) conclude 'Effective psychological interventions constitute a much-needed addition to antidepressant medication for depressed older patients'.

Gatz *et al.* (1998) reviewed the empirical evidence for the psychological treatment of depression in older adults. Using criteria developed by the Division of Clinical Psychology of the American Psychological Association, Gatz and colleagues came to the conclusion that CBT meets criteria as a *probably efficacious* treatment. According to Gatz *et al.* (1998) CBT did not meet criteria as a well established treatment because 'superiority to psychological placebo has not been demonstrated with sufficiently large samples, and superiority to another treatment has not been found with sufficient consistency'. The conservative conclusion drawn by Gatz *et al.* (1998) may well be warranted at this stage as too few studies have been conducted to properly evaluate cognitive therapy's efficacy. A conclusion mirrored by Koder *et al.* (1996) in their recent meta-analysis. It is hoped that future research will establish whether badly needed psychological treatment alternatives for late life depression can be accepted as having well established treatment status according to strict criteria such as those set by the APA. Meta-analyses (see Table 1) such as the aforementioned do tell us that psychological treatments are effective in producing change, however individual research studies provide evidence for efficacy of different treatment interventions.

OUTCOME STUDIES IN COGNITIVE THERAPY FOR LATE LIFE DEPRESSION

A number of methodological differences across studies investigating outcome of psychological treatments for late life depression makes cross comparison difficult. Some studies do not include control conditions (Steuer *et al.*, 1984; Fry, 1984; Leung and Orrel, 1992). Only one study produced information on longer term follow-up of up to 2 years (Gallagher-Thompson *et al.*, 1990). While a number of the studies identified in Table 2 do report follow-up data, many studies report follow-up at 3–6 months which is considered inadequate. Some studies have evaluated group cognitive therapy (Steuer *et al.*, 1984; Beutler *et al.*, 1987; Kemp *et al.*, 1991/2; Leung and Orrell, 1992; Arean *et al.*, 1993; Rokke *et al.*, 2000) whereas others have evaluated individual cognitive therapy (Gallagher and Thompson, 1982, 1983; Thompson *et al.*, 1987; Gallagher-Thompson *et al.*, 1990; Gallagher-Thompson and Steffen, 1994; Kaplan and Gallagher-Thompson, 1995; Dick and Gallagher-Thompson, 1995).

A summary of the main studies looking at CT for older adults is provided below in Table 2. Studies are included in Table 2 if they evaluate cognitive-behavioural treatment for late life depression and if they report data using the Beck Depression inventory (BDI: Beck *et al.*, 1961) and the Hamilton Rating Scale for Depression (HRSD: Hamilton, 1967) as these measures are the main outcome measures used in many research studies allowing comparison of differential treatment effectiveness. Unfortunately Kemp *et al.* (1991/2) did not report BDI and HRSD data and are therefore not included in Table 2. However, since they report on a cognitive-behavioural intervention this study is considered in the verbal review. As will be seen there are generally very few studies investigating treatment effectiveness in this population. In this review nine studies in total taking place between 1982 and 2000 have been identified using some form of cognitive therapy in comparison to another form of treatment. In their review Koder *et al.* (1996) identified six studies which compared the efficacy of cognitive therapy in the treatment of depression in older people. Table 2 includes five studies that appeared in the review by Koder *et al.* (1996) and an additional three studies not present in that review Leung and Orrel, 1992; Arean *et al.*, 1993; Rokke *et al.*, 2000). Arean *et al.* (1993) and Rokke *et al.* (2000) use a form of cognitive-behavioural therapy that is not too dissimilar to Beck's model for cognitive therapy and report outcome using the BDI and HRSD and therefore merit inclusion in this review.

In the eight studies included in Table 2, there are no significant differences in efficacy between active treatments. In terms of attrition rates there are wide variations across studies. Surprisingly few studies have reported upon comorbidity of physical illness,

with the studies that do, reporting very high rates of physical illnesses (Steuer *et al.*, 1984; Rokke *et al.*, 2000). It is evident from Table 2 that the majority of studies have very small sample sizes.

Thompson, Gallagher-Thompson and colleagues have carried out the most systematic investigations of the effectiveness of CT for the treatment of late life depression. Gallagher and Thompson (1981) produced one of the first treatment manuals for applying cognitive and behavioural techniques with older people. Subsequently the same group have produced periodical updates of their cognitive therapy treatment manuals for the treatment of depression in older people (Thompson *et al.*, 1995, 2000). In one of the first studies to evaluate cognitive-behavioural therapy's effectiveness as a treatment for late life depression, Gallagher and Thompson (1982, 1983) assigned participants to either behavioural, cognitive or psychodynamic (insight-oriented) psychotherapy. The results set a trend that was to be repeated in practically every other study comparing psychotherapy effectiveness with older adults; all three treatment approaches were equally efficacious, despite apparent differences in treatment content and style. Indeed Gallagher-Thompson and Thompson (personal communication) note that in all their studies they have been very careful to ensure that treatment within each type stays within modality by ensuring that competence in the delivery of therapies is evaluated by the originators of each type of therapy. Gallagher and Thompson (1983) note that participants considered to have an 'endogenous' type of depression fared much more poorly than did participants not meriting this diagnosis. Thompson *et al.* (1987) randomized 91 outpatients diagnosed with major depresive disorder to one of the three treatment conditions; cognitive, behavioural and insight-oriented psychotherapy. From Table 2, it can be seen that there were no differences between the active treatments and there are significant treatment effects compared to the waiting list control condition. Gallagher-Thompson *et al.* (1990) reported that gains made initially by patients were maintained at 1-year follow-up with 52, 58 and 72% of patients who received cognitive, behavioural and psychodynamic treatments respectively, remaining depression free.

Steuer *et al.* (1984) report CBT treatment as more effective than psychodynamically oriented treatment when using the BDI as the main criterion for measuring change. This finding is reflected in effect sizes calculated for each condition whether using the BDI or HRSD as shown in Table two. Steuer *et al.* (1984) conclude that this statistical difference is really an artefact of the treatment that patients received. The assertion is that CBT effectiveness may be overestimated when using the BDI as cognitive therapy and may 'teach' patients how to answer this scale (Steuer *et al.*, 1984). However, Riskind *et al.* (1985) find this explanation unconvincing providing evidence that suggests BDI scores are meaningful and are more conservative in detecting change than the HRSD. This assertion is supported by Engels and Verney (1997) in their meta-analysis in which effect sizes for BDI scores are much more conservative in showing change than those reported using the HRSD.

In the Beutler *et al.* (1987) study, cognitive therapy plus placebo produces the largest effect sizes of all treatments combinations using the self-report of patients on the BDI. Cognitive therapy and placebo appears more efficacious in comparison to cognitive therapy in combination with medication in this study. It is interesting that this study has very high attrition rates for medication groups, double that of non-medication treatment groups. This result perhaps indicates that the side-effects of medication proved intolerable to patients in this trial or that this medication was not appropriate for this study. In this study the observer-rated measures appear to contradict the patient's self-reports. Using the HRSD, cognitive therapy plus placebo produces the smallest effect size apart from placebo on its own.

Leung and Orrell (1992) report on an interesting group cognitive therapy intervention. The intervention was very brief, a series of seven weekly sessions lasting 90 min. Despite the brevity of intervention Table 2 shows that this study nonetheless produced moderate effect sizes. It is noteworthy that many of the patients taking part in this study satisfied criteria for major depressive disorder and still found this brief intervention efficacious. There were no control groups or comparisons to this intervention. Kemp *et al.* (1991/2) also carried out a brief 12-week group cognitive therapy intervention and compared individuals with and without disabling illnesses. While both groups benefited from the intervention, the non-disabled group continued to improve at 6 months follow-up whereas the disabled group did not. The authors noted that the disabled group appeared to do less well at follow-up as they experienced additional health problems which interfered with their levels of functioning.

Arean *et al.* (1993) evaluated problem-solving therapy (a form of cognitive behavioural therapy) in comparison to a life review group intervention and in comparison to waiting list controls. Both active

treatment conditions proved efficacious although problem solving appears to result in better outcome than reminiscence. From Table 2 it is evident that the problem-solving intervention produces larger effect sizes on both the BDI and HRSD. On the BDI data the problem-solving group produce very large effect sizes whereas the reminiscence/life review group produce moderate to large effect sizes. Arean *et al.* (1993) note that in their analyses there were significant differences evident between the treatments on the HRSD measure and not on the BDI.

Rokke *et al.*'s (2000) brief group intervention comparing therapy with psychoeducation showed that both the interventions were beneficial for depressed older adults. The interventions were relatively brief lasting for 10 sessions. This study had very small sample sizes and this lack of statistical power may account for the equivalence of results. From Table 2 it is evident that the therapy intervention produces larger effects than the psychoeducational intervention.

In summary then, evidence has accumulated to support the applicability of psychological treatments for late life depression. Evidence is lacking in terms of being able to specify which particular type of therapy is most effective for late life depression although with reference to Table 2, it would appear that cognitive therapy is an effective treatment for depression in older people. By calculating effect sizes for each intervention, it is clear from Table 2 that while all interventions appear efficacious for the treatment of late life depression, there is a clearer picture that emerges when looking at the level of effect sizes. From Table 2, in every case using BDI data, cognitive-behavioural methods of treatment produce the largest effect sizes of treatments within each study. This is an important finding given the generally conservative nature of this instrument for showing change. The importance of this finding is emphasized by the fact that it reflects the self-report of patients themselves. Thus, while significant differences may not always be apparent between treatments there is good evidence that cognitive therapy is a very effective treatment for late life depression. Reviewing the literature on outcome studies into the effectiveness of CT with older adults it is evident that further research is required as many studies carry with them significant methodological shortcomings.

Sample sizes in research conducted to date is small and hampers comparison between treatment options. If future studies are large enough more sophisticated subdivision of analysis can be performed such as evaluating whether length of episode has any impact on outcome, investigating differential outcome between early versus late onset depression, etc. Cost evaluation is becoming more important in measuring whether treatments ought to be available. In view of the relatively expensive treatment costs of psychotherapy versus the relatively cheap (in the short-term) costs of medication, evaluation of this dimension of outcome research needs a higher profile. If cognitive therapy can demonstrate that successful treatment has a positive impact on relapse and recurrence rates in depression then this treatment option would have strong financial in addition to strong scientific reasons for use with older people with depression.

THE IMPACT OF RESEARCH ON CLINICAL PRACTICE

Before turning to a discussion of the relevance of these research findings to clinicians working with older adults it is important to recognize that research studies are often carried out in conditions quite different from those in the clinical setting. Space does not permit a full examination of this controversial and very relevant clinical debate so the interested reader is directed to Persons and Silberschatz (1998) for an excellent discussion on whether randomized controlled trial data is meaningful and useful to clinicians. It is true that there very often exists a gap between efficacy and effectiveness. Despite evidence generated in clinical trials for a treatment intervention it is often found that in the 'real world' treatments prove much less efficacious. There are many reasons put forward for this, such as the difference that exists between patients participating in research trials and those presenting in primary care settings. Patients in primary care settings may have multiple comordibities of other illnesses, both physical and psychological. Clinicians treating patients in these settings may be faced with issues of polypharmacy. In clinical settings patients may also have different social and economic problems not considered in clinical research. Most of the aforementioned differences (comorbidity, polypharmacy, socioeconomic problems) would automatically exclude many patients from taking part in clinical research trials.

In terms of psychotherapy research it is clear that therapists in research settings are highly trained in their particular therapy approach and show a high

degree of commitment to their therapeutic models thus enhancing outcome (see Robinson *et al.*, 1990). Often in research settings, therapists adhere strictly to treatment manuals. It is again suggested that these factors distance clinical research from that practiced in clinical settings. Whilst criticism of randomized controlled trial (RCT) methodology is in many ways justified, there are a number of cogent reasons to continue to use evidence from RCTs. Clinicians have a responsibility to provide their patients with the most effective treatment, the evidence from RCTs is currently our best guide (although flawed) for the clinician who wants to be sure that they are employing the most effective interventions for any given condition or population. Thus the issue of whether adaptations are necessary for cognitive therapy to be effective with older aduts needs to be informed in part from this literature. In the case of psychotherapy for older adults, 'scientific-repectability' can be gained with other professional groups by the use of RCT methodology. Overall rather than abandoning research evidence, the careful clinician interprets research findings in context and applies them accordingly. For clinicians to be able to take results from randomized controlled trials more seriously it is necessary for emphasis to be placed upon effectiveness as well as efficacy.

ARE ADAPTATIONS TO COGNITIVE THERAPY REALLY NECESSARY FOR OLDER ADULTS

The issue of whether cognitive therapy needs to be adapted in order for it to be effective for use with older adults is an important one. According to Unutzer *et al.* (1999) chronic medical illness constitutes the most important factor distinguishing older adults from those aged 65 years or less. Engels and Verney (1997) in their review of psychotherapy efficacy raised the possibility that 'older' old patients did not benefit from psychotherapy as much as the young-old patients because adaptations did not take into account age limitations. Koder *et al.* (1996) state 'The debate is not whether CT is applicable to elderly depressed patients, but how to modify existing CT programmes so that they incorporate differences in thinking styles in elderly people and age related psychological adjustment'. If adaptations are required the clinician is entitled to ask, what adaptations under what circumstances?

WHAT ADAPTATIONS AND UNDER WHAT CIRCUMSTANCES?

It is important that the potential therapist with older adults understand that this group is *the least* homogenous of all age groups and older adults often have many more dissimilarities than similarities (Steuer and Hammen, 1983; Dick and Gallagher-Thompson, 1995). As Zeiss and Steffen (1996a) point out there are at least two generations contained within this age grouping and a clinical implication of the variability amongst this group is that modification to therapy procedures are not always necessary. Chronological age is the least good marker for determining whether therapeutic adaptations are necessary (Zeiss and Steffen, 1996b).

The position advocated here is that major adaptations should not be considered necessary in every case when working with an older adult. Modification of therapy may be indicated and may be required to take account of issues to do with normal age-related changes such as the presence of chronic physical illness and slowed cognitive processing (Gallagher-Thompson and Thompson, 1996). There is a great deal of individual variation in this section of the population. One of the strengths of cognitive therapy lies in its flexibility of approach and application. One of the most important emphases in the application of cognitive therapy is the development of an awareness of the idiosyncratic nature of an individual's problems. As Knight (1996) reminds us, the problems threatening emotional 'homeostasis' in older people are generally the same problems threatening equilibrium at any time in the life span. The problems that older adults bring into therapy may not be unique to old age but may be more likely. As Beck (1995) suggests, cognitive therapy is based upon a constantly evolving formulation of the person and their perceived problems in terms of a cognitive conceptualization. Thus by definition cognitive therapy is particularly appropriate as an intervention for older adults as it takes into account normal age-related changes in the formulation of an individual's problems (Thompson, 1996).

The point being made here is a subtle but important one; that adaptations are not *necessarily* essential in order for cognitive therapy to be effective with older people (Steuer and Hammen, 1983; Zeiss and Steffen, 1996a, b). This position is not necessarily advocated when working with very frail older adults (Grant and Casey, 1995) or those with cognitive impairment (Teri *et al.*, 1997). It is easy for the message to get confused here; it

is advocated that major adaptations to cognitive therapy are not necessary and yet it is also recognized that modifications to therapy such as pacing may be necessary taking into account cognitive slowing or changes in sensory perception (vision and hearing). In more ways than not cognitive therapy with older people is similar to therapy with younger people. When it is argued that adaptations are unnecessary, the assertion is that structural elements of cognitive therapy such as agenda setting, collaborative empiricism, cognitive conceptualization, cognitive restructuring and homework setting are all essential elements. Contrary to suggestions made by Koder *et al.* (1996) life review is not necessarily part of cognitive therapy with older adults. This is not to say that review of life experiences is unnecessary in certain individual circumstances; understanding an individual's problems very often requires taking the historical context into account. It is argued that to suggest life review is necessary as older adults are at a late stage of life is misleading and potentially unhelpful. Cognitive therapy is a relevant and accessible therapy precisely because it deals with older people's current concerns, whether that is grief, physical limitations following a stroke or general emotional distress.

There is an important distinction to be made here between adaptations and treatment modifications. Modifications (see Zeiss and Steffen, 1996a) are intended to enhance treatment outcome within the model of therapy (i.e. CT), whereas adaptations are intended to alert clinicians to the possibility that the treatment model they have chosen may be inadequate for the circumstances. It is this position which is potentially misleading for clinicians inexperienced in working with older adults.

The debate over whether adapatations are necessary is an important one. In the past assumptions have been received into the literature that require challenging as they are potentially misleading, unhelpful and unwise. Church (1983) suggests that older adults are less able to benefit from verbal and abstract aspects of therapy and cites evidence that a group of patients attending a day hospital experienced difficulty completing thought records. Church (1983) concludes that older adults may benefit more from concrete activities. The implication that can be drawn here is that cognitive restructuring is unlikely to be beneficial for older adults in therapy. As has been stated earlier the variability of this population make such statements potentially misleading and unhelpful to clinicians working with odler adults. As Zeiss and Steffen (1996b) note 'the direct clinical implication of this increased variability is that, when working with older adults, it is important not to assume that specific adaptations of CBT will be needed'.

Two pieces of evidence from the empirical literature caution the clinician about drawing the conclusion that in order for cognitive therapy to be effective with older people it requires to be adapted. The first piece of evidence against adaptation of CBT comes from the meta-analysis literature. Results of meta-analyses carried out in older adult populations report near identical effect sizes to those reported by meta-analyses studies looking at CBT across all age groups. The second piece of evidence suggesting that adaptations do not necessarily need to be made in order for CBT to be effective with older adults comes from the literature on outcome studies. Gatz *et al.* (1998) in their review of empirical evidence of psychological treatments for late life depression note that in studies little fundamental adjustment of techniques appears to be necessary. In other words, outcome studies produce similar results in older adults receiving CBT in comparison to findings reported from studies looking at the under-65-year-old population. Thus the conclusion to be reached is that CBT is equally efficacious in younger and older age groups and this is using CBT *without* adaptations. The idea that CBT has to be adapted for use with older people (see Wilkinson, 1997) has another very unfortunate side-effect. The large body of empirical evidence accumulated over the years demonstrating the effectiveness of CBT as an effective treatment alternative to antidepressant medication is disregarded because of questions about relevance.

In summary it is argued that there is no empirical evidence or therapeutic necessity to adapt cognitive therapy in order to make it suitable and accessible for older adults without cognitive impairment or in the absence of frailty. For older adults with cognitive impairment there are indications that cognitive-behavioural approaches may still be valid (Teri and Gallagher-Thompson, 1991) and efficacious (Teri *et al.* 1997). The structural elements of standard cognitive therapy with younger adults remain and are equally important in their application with depressed older adults. The use of agenda setting, and the centrality of the concept of collaborative empiricism are deemed essential elements of 'good' cognitive therapy. The essential therapeutic ingredients such as the socratic mode of questioning and use of guided discovery for the investigation of idiosyncratic beliefs, are considered to be as

accessible for older adults as for younger adults. Focusing on what adaptations are necessary means that the empirical body of research supporting the efficacy of standard cognitive therapy is not necessarily seen as applicable for therapy conducted with older adults.

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COMPREHENSIVE CONCEPTUALIZATION OF COGNITIVE BEHAVIOUR THERAPY FOR LATE LIFE DEPRESSION

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Abstract. Cognitive behaviour therapy (CBT) has proven efficacy as a treatment for depression in older people. An important debate amongst therapists working with older people is whether CBT needs to be adapted to ensure optimal treatment outcome and, if so, what adaptations are necessary. It is accepted that psychotherapy with older people can differ from psychotherapy with younger people in a number of important respects because of the higher likelihood of chronic conditions, changes in cognitive capacity, potential loss experiences and different cohort belief systems. As psychotherapists are often much less comfortable dealing with physical problems, they may become negatively biased in terms of outcome when patients present with co-morbid health issues. The impact of loss experiences in older people can also be overemphasized in their importance by inexperienced therapists and can result in lowered expectations for therapy outcome. Consequently, there is a need to develop a model that addresses age related issues within a coherent cognitive therapy framework suitable for older people. This paper describes a CBT model that is augmented with applied gerontological knowledge, taking account of cohort beliefs, intergenerational linkages, sociocultural context, health status/beliefs and role investments/transitions. Clinical examples are used throughout to illustrate clinical implications of the model.

Keywords: Cognitive behavioural therapy, gerontology, generativity, cohort, late life depression, longevity, successful ageing.

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Depression in later life

Treatment for depression in older people is commonly managed by GPs in Primary Care settings (Rothera, Jones, & Gordon, 2002) with infrequent referrals to secondary specialist services (Laidlaw, Davidson, & Arbuthnot, 1998; Collins, Katona, & Orrell, 1997; Orrell, Collins, Shergill, & Katona, 1995). Although GPs primarily use antidepressants to treat depression in older people, many prescribe sub-therapeutic dosages of antidepressants because of fears about side effects (Katona & Livingston, 2002; Isometsa, Seppala, Henriksson, Kekki, & Lonnqvist, 1998; Heeren, Derksen, Heycop, & Van Gent, 1997; Orrell et al., 1995). Additionally, amongst older people there is a low rate of compliance with antidepressant prescriptions because they may already be using a large number of medications for a range of conditions (Katona & Livingston, 2002; Unutzer, Katon, Sullivan, & Miranda, 1999). With many older people now expressing a preference for psychotherapy as a treatment for depression (Landreville, Landry, Baillargeon, Guerett, & Matteau, 2001), it is clear that psychotherapeutic alternatives constitute a welcome addition to the treatment of late life depression (Gerson, Belin, Kaufman, Mintz, & Jarvik, 1999).

Cognitive Behaviour Therapy (CBT) is a very relevant form of psychotherapy with older people (Morris & Morris, 1991) as it is an active, directive time-limited, structured problem-solving treatment approach whose primary aim is symptom reduction. The application of CBT with older people is comprehensively described in Laidlaw, Thompson, Dick-Siskin and Gallagher-Thompson (2003). Primarily, research into CBT for late life depression has largely focused on outcome, while generally ignoring the importance of process issues.

Why do we need a conceptualization of CBT specific to older adults?

Since CBT outcome research demonstrates that unmodified and non-adapted CBT is efficacious for older people (Laidlaw, 2003a, 2001; Gatz et al., 1998; Koder, Brodaty, & Anstey, 1996; Scogin & McElreath, 1994), one might enquire as to why a specific CBT conceptualization, that modifies and extends the bounds of therapeutic investigation, is really needed with older adults. There are, however, a number of reasons why a specific conceptualization framework is needed. For example, at the end of an empirical review of CBT efficacy with older people, Koder et al. (1996) conclude, "The debate is not whether CT is applicable to elderly depressed patients, but rather how to modify existing CT programmes so that they incorporate differences in thinking styles in elderly people and age-related psychological adjustment". Koder et al. (1996) also argue that Life Review and Reminiscence can be usefully incorporated into CBT treatment programmes. Likewise, earlier cognitive therapy researchers have also stated that cognitive therapy needed to be adapted for use with older people, suggesting that "abstract" elements of therapy such as cognitive restructuring may not be beneficial, or perhaps even possible with many older people (Church, 1983, 1986; Steuer & Hammen, 1983). This is potentially confusing for some therapists as it suggests that unless one substantially alters one's practice, standard CBT approaches are not applicable with older people.

Further, because of an overemphasis on negative changes in later life, such as loss, bereavement and physical illnesses, some therapists may be sceptical about applying "standard" CBT (Laidlaw, 2003a). Padesky (1998) suggests the ultimate effectiveness of CBT may be enhanced or undermined by a therapist's own set of beliefs. Certainly, changes

in cognitive capacity, potential loss experiences and different cohort belief systems can leave some therapists feeling out of their depths, and at a loss as to how to apply psychological interventions in the face of "external" rather than internal difficulties.

Many experienced therapists working in the field consider standard CBT conceptualizations are inadequate as a description of the complexity of the age-specific issues facing their clients. The comprehensive conceptualization framework applied here with older people provides an answer to such criticisms and applies gerontological knowledge that is consistent with clinical emphasis important to any therapist working with their patient. Simply put, the more authentic and collaborative the understanding that develops between the patient and the therapist, the better the outcome is likely to be (Persons, 1989). Hence, the current paper seeks to find a way to incorporate age-related differences within standard CBT frameworks using a comprehensive conceptualization framework for older people. For CBT with older people, modifications rather than adaptations may be all that is required (Laidlaw et al., 2003). Modifications suggest that treatment outcome can be enhanced by consideration of certain client specific variables, whereas adaptations require that substantive changes are necessary to a treatment model in order for it to be effective with any specific client group (Laidlaw, 2001). In summary, there is a need to develop a conceptualization model for older people that addresses age related issues within a coherent cognitive therapy framework suitable for older people (Grant & Casey, 1995).

A comprehensive conceptualization of CBT for older people

A brief description of each element of the conceptualization framework of CBT for late life depression is illustrated in Figure 1. At the centre of this conceptualization framework is the standard CBT model for depression (Beck, Rush, Shaw, & Emery, 1979), reflecting the focus that is placed upon standard CBT techniques for treatment interventions. Each element of the conceptualization framework is discussed in greater detail below and clinical examples are used to illustrate key issues.

Cohort

Cohort beliefs are those beliefs held by groups of people born in similar years or similar time periods (Neugarten & Datan, 1973). Cohort beliefs are the shared beliefs and experiences (cultural and developmental) of age specific generations (Smyer & Qualls, 1999). It follows that certain cohort beliefs may impact on the process and outcome of psychotherapy. Knight (1996) emphasizes this when he states that working with older adults entails learning something of the folkways of people born many years before. People born at the beginning of the 20th century will have different cultural and socio-historical experiences to those born at the end of the 20th century and hence may develop different cohort beliefs. It is, however, more than just a "generation gap". Historical events can have had tremendous impact on developmental experiences, leading people to develop different expectancies and beliefs about life. Laidlaw et al. (2003) state "Understanding cohort experiences, and taking these into account when working psychotherapeutically with older people, is no more difficult and no less important than when working with cohorts such as ethnic minority groups." Cohort differences become apparent if one reflects on the experiences of someone growing up in the 1930s, where

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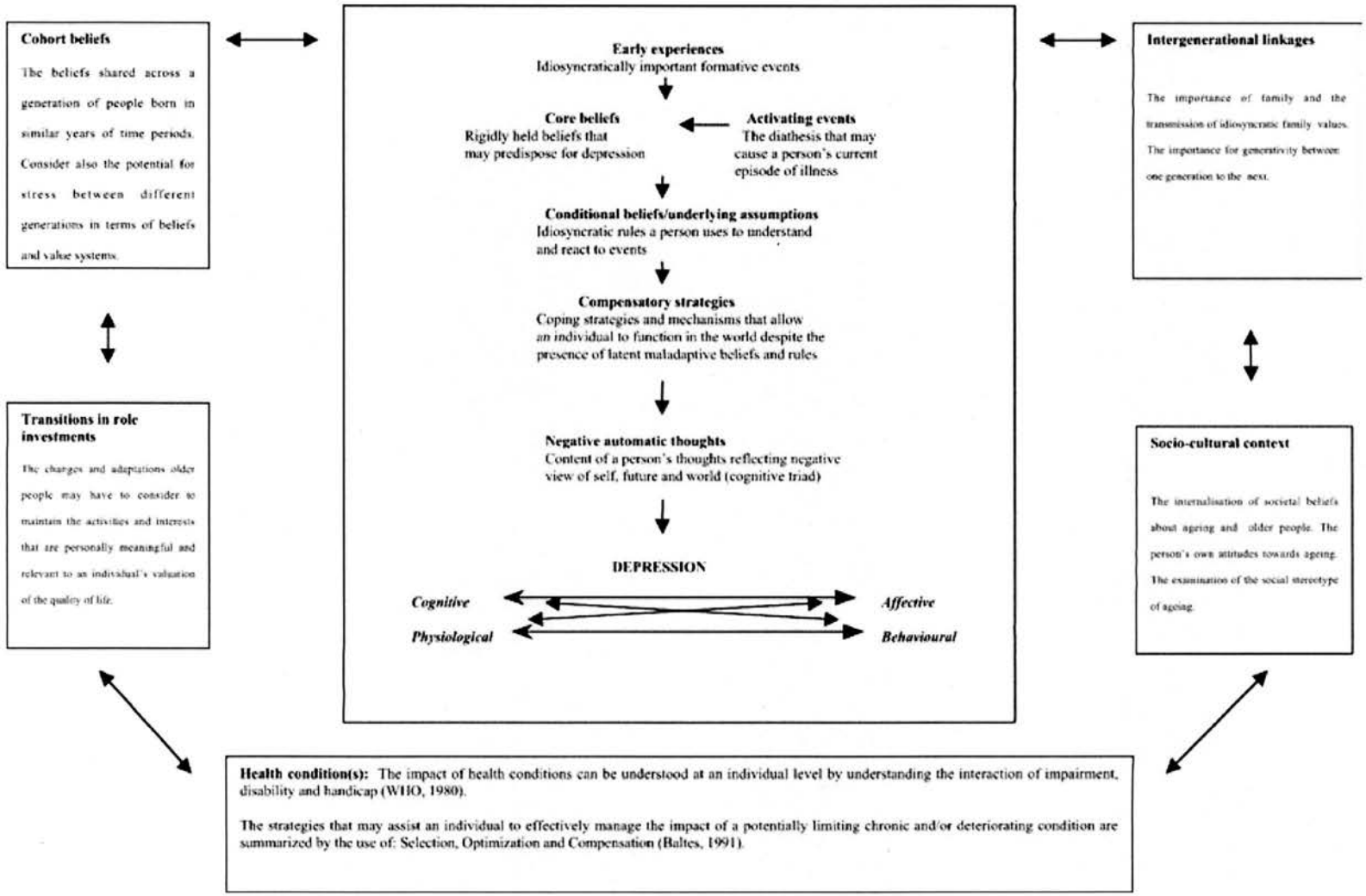

Figure 1. CBT conceptual framework for older people

great historical events like the Great Depression or World War II occurred and became shared socio-historical experiences. Cohort experiences produce potential for misunderstandings and miscommunication between generations. Cohort beliefs of older generations can also sometimes clash with the therapist's beliefs. For example, beliefs about lifestyle choices, and gender roles may differ markedly, making therapists feel uncomfortable.

Combining cohort beliefs with idiosyncratic core beliefs provides an age and generational context to therapy work. For instance, discussing how depression was understood within a specific age cohort and how this relates to personal beliefs about failure can provide a therapist with an opportunity to provide psychoeducation about depression. It may also help one to discover more about the individual's belief system and coping strategies. Lebowitz and Neiderehe (1992) state, "The stigma of mental illness is especially strong in the current cohort of elderly people, who tend to associate mental disorder with personal failure, spiritual deficiency, or some other stereotypic view." For instance, Mr Robson had been experiencing depression since he retired from a lifetime working with a local firm of builders. Mr Robson also experienced significant problems with agoraphobia and rarely left his house. Although Mr Robson was a keen gardener, he found it extremely difficult to be seen outside by people walking past his front garden. It appeared that Mr Robson had always strongly ascribed to the cohort belief that depression was a shameful mental illness. Thus he avoided people seeing him for fear that others were judging him as deficient and mentally abnormal. This cohort belief was extremely painful and he could not avoid experiencing deep feelings of shame and guilt. The impact of these emotions prevented him from managing his depressive symptoms, further confirming his belief that he was weak and a failure as a man. The therapist sought to normalize Mr Robson's fears by explaining that his generational cohort may have shared similar beliefs, but such perspectives would no longer be shared generally by society; especially, given changes in knowledge about mental illnesses. This intervention also introduced some flexibility into a belief system that was rigid and maladaptive. It is noteworthy that treating his avoidance as simple agoraphobia would have probably resulted in a misdirected effort on the part of the therapist.

Transitions in role investments

Active engagement in life is considered an important determinant of successful ageing (Rowe & Kahn, 1998) and often for an older adult this means maintaining close relationships with family and loved ones. For an older adult, remaining invested and involved in activities and interests that are personally meaningful, purposeful and relevant (Rowe & Kahn, 1998) is likely to improve quality of life and especially mental and emotional functioning (Laidlaw, 2003b; Vaillant, 2002). Role investment is therefore an important variable to evaluate in any conceptualization with older adults. Also, at this stage in one's life there may be transitions that an individual needs to navigate in order to successfully adapt to age related changes. Champion and Power (1995) state that vulnerability to depression is related to the extent to which an individual invests in certain highly valued roles and goals. Over investment, that is investment in certain roles and goals to the exclusion of all others, may constitute vulnerability for the development of depression. Champion and Power (1995) recognize a gender bias in the sorts of roles and goals that are invested in. Women are more likely to invest in interpersonal relationships and men are more likely to invest in areas of achievement-orientation, such as work. An important role transition for some, though not all older people, is signalled by

occupational retirement. Generativity, the concern for and commitment to the wellbeing of one generation for another (Erikson, 1997), is considered an important element in the successful ageing of an individual (Vaillant, 2002). Mr Kirk was a successful expatriate engineer who prior to retirement was strongly invested in his work, like many men of his generation. His work provided an important method of self-definition, validation and indication of self-worth. An key role for Mr Kirk was a generative one; he liked to pass on knowledge and experience to his fellow workers (his company employed him to consult and teach younger engineers prior to his retirement) and to his adult children. On retiring from engineering, Mr Kirk returned "home" to Scotland. On his return, Mr Kirk quickly became depressed as a number of important roles had become lost to him. His adult children had remained abroad and he no longer felt needed. He applied to provide voluntary advice to a local engineering college but he was rejected because of his age. For Mr Kirk, CBT interventions focused upon reconstructing a new way of maintaining a sense of investment in activities of personal meaning. Hence, transitioning from one way of achieving meaning to an alternative way that was adaptive to the change in circumstances. Thus, an important element of therapy was finding ways in which he could continue to feel important and valuable to society. Mr Kirk invested his time in voluntary activities by joining the board of a local charity and importantly investing his time in education, enrolling in an Open University course. By investing in these activities, Mr Kirk gained a new sense of value that linked meaningful values from the past. He was able to maintain a sense of continued growth and potential, an aspect of life that is so important for successful ageing and longevity (Vaillant, 2002).

Intergenerational linkages

With the change in family and society demographics (increased longevity, smaller family sizes, increased rates of divorce and subsequent re-marriage) grand parents and great-grandparents perform an important role in our societies, providing strong intergenerational linkages across families (Bengtson & Boss, 2000; Bengtson 2001). Older generations tend to value continuity and transmission of values, whereas younger generations tend to value autonomy and independence (Bengtson et al., 2000). Intergenerational relationships can often create tensions, especially when older generations do not always either approve of, or understand, changes in family structures or marital relationships (Bengston et al., 2000).

For many older people, intergenerational linkages may be confusing and distressing as they clash with cherished cohort beliefs about the notions of family. Neugarten, Moore, & Lowe (1965) introduced the concept of the social clock in which people have certain socially influenced (and hence cohort) notions about the timetable for accomplishing life's tasks. For example, older generations may express disappointment or disapproval at their adult children if they have not settled down and started a family by their thirties. The increase in longevity may result in certain life stages being reached at different ages for different generation cohorts, resulting in misunderstandings and tensions across generations. Levine (1996) notes that older women may have different expectations about marital fulfilment and roles in society compared to younger women. Levine (1996) also notes that differences in expectations may become an important relationship issue to address in therapy.

Thompson (1996) notes that it is common for relationship strains between older adults and their adult-children to precipitate a depressive episode. Parents, regardless of the age of their children, often still retain a sense of responsibility for things that affect their children.

In depression, this sense of responsibility can become magnified. For example, Mr Ross felt a sense of having let his youngest son down when he learnt that his son had separated from his wife. He stated, "I've obviously not done the right things by him" and "If we had stayed, we might have been able to help . . . we might have prevented the divorce." Cognitive methods of thought challenging were the principal, and successful, method of dealing with this presentation. Eventually, Mr Ross was able to state, "I lived in the same district as my oldest son and that did not prevent him from divorcing." Mr. Ross was also able to see why his youngest son had originally hid his marital difficulties from him. He was able to accept eventually that this was not because his son didn't respect or need his father's advice, but probably because the son felt he had failed at his marriage. Mr Ross was also able to state that he understood that this was a common and understandable reaction on the part of anyone experiencing marital difficulties.

Socio-cultural context

The variable of interest here is primarily people's attitudes towards their own ageing. Often patients will explicitly state that "growing old is a terrible thing". Statements such as this may appear to be realistic appraisals of a difficult time of life, but in fact reveal the internalization of socio-cultural negative stereotypes about growing old. As Levy (2003) states "when individuals reach old age, the ageing stereotypes internalized in childhood, and then reinforced for decades, become self-stereotypes." Many older people have an implicit assumption (that can be challenged in therapy) that old age inevitably means loss and decrepitude. As one gets older, the growing sense of dread about what ageing will bring can often be accompanied by an increased vigilance for the first signs of the "the slippery slope". Thus many older people have a latent and potentially maladaptive vulnerability about ageing that has been reinforced and often endorsed by themselves and society for decades. Hence, older people may assume that if they are unhappy or depressed that this is a normal part of ageing. Unfortunately, beliefs such as these often prevent individuals from seeking treatment or at the very least making the most of treatment when it is offered (Unutzer et al., 1999). Therapists ought to explore the socio-cultural context of the patient when they are socializing the patient into therapy. Formulations of beliefs about ageing are very important if therapy is to proceed in a timely and efficacious fashion. The socio-cultural context also takes into account the values of the therapist. One must work to develop a realistic understanding of ways of working with older people. There are many erroneous "age related" negative cognitions that may sound "understandable" to younger therapists: such as, "Old age is a terrible time", "All my problems are to do with my age", "I'm too old to change my ways now". To avoid endorsing such concepts, it is important that therapists ask themselves a few key questions: "Would I accept this cognition as fact in a younger patient?" and "Would I accept the limitations this person places on his expected outcome in therapy in someone younger?"

Physical health

Increasing age brings with it an increased likelihood of developing chronic medical conditions. However, it does not follow that all older people have a chronic medical condition that has a limiting functional effect. In any formulation it is important to enquire about the presence and impact of medical conditions (Zeiss, Lewinsohn, Rohde, & Seeley, 1996). Equally, it

is important to enquire about patients' understanding about diseases and to examine what they think will be the outcome of any chronic condition. In the cognitive model for late life depression, health status is formulated using the WHO (1980) classification of disease where physical ill-health is understood in terms of three components: impairment, disability and handicap. This is an extremely useful way for therapists to conceptualize illness. In this system, impairment refers to any loss/abnormality of body structure, appearance, organ or system. For example, in the case of someone having a stroke, the impairment would refer to the damage caused to neural tissue caused by the vascular event. Disability is the impact of the impairment on the individual's ability to carry out "normal" activities. So, following a stroke, the person may now find it difficult to dress himself without assistance. Handicap can be thought of as the social impact that the impairment or disease has on the individual. Consequences of handicap are reflected in the disadvantages an individual experiences in his interaction with, and adaptation to, the environment. Thus the person who experienced the stroke may find that other people now treat him differently, and he increasingly feels excluded from normal communications. The notion of handicap is useful for looking at the consequences of disease for an individual. Indeed, it highlights the loss of opportunity to participate in society that many older people will experience should they develop certain disease conditions. In this tripartite framework, it is apparent that the way a person copes with the disability and handicap components is under much more conscious control by the individual as compared to impairment component. The usefulness of this system to psychotherapists is that it allows one to consider the consequences of impairment or disease for an individual. While this system of classification has recently been superseded by a framework that more explicitly focuses on a more complex way of formulating health status (WHO, 2001), the simplicity of this model makes it useful.

A further helpful way of conceptualizing ill health is via Baltes' (1991) components of successful ageing. In this latter framework, individuals select a limited set of behaviours that they optimize to allow them to compensate for any limitations due to illness (SOC: selection, optimization and compensation). Use of these strategies can enable an older adult to accommodate to the changes associated with ageing and promote maximal independent functioning even in the presence of a chronic disabling condition. The model is exemplified by Baltes (1991), with reference to the concert pianist Arthur Rubinstein who continued to perform at an exceptional level late into life. When asked for the secrets of his success, Rubinstein mentioned three strategies. First, he reduced the scope of his repertoire (an example of selection), and secondly, Rubinstein, practised this repertoire more intensely than would have been the case when he was younger (an example of optimization). Finally, Rubinstein used "tricks" such as slowing down his speed of playing just immediately prior to playing the fast segments of his repertoire, thereby giving his audience the impression of faster play than was actually the case; an example of compensation for the effects of ageing on speed. Thus the psychological consequences of physical illnesses can be dealt with by first understanding the disability and handicap experience by the individual and then managing this by developing creative solutions using the SOC model (Baltes, 1991).

Concluding thoughts

Within this comprehensive conceptualization framework, a developmental approach is adopted across the entire lifespan of the individual. Later life is seen as another stage of life that shares

similarities with all other stages of life. Transitions and challenges will have to be faced by the individual in order to maximize his emotional and physical independence. Adopting this perspective gives CBT therapists a rationale for treatment. The authors have found that mapping out the various domains has helped many therapists specializing in the field to conduct assessments, and consequently interventions, in a more focused manner. For example, the explication of the physical domain has provided therapists with a treatment rationale even where depression is considered to be a "biological" effect of illness, such as in stroke or heart disease. An important attribute of this conceptualization framework is that elements overlap and interact. Indeed, as outlined earlier, cohort beliefs may influence how an individual reacts to a change in health status ("I must not be a burden to my family"), and may determine some aspects of an individual's sociocultural beliefs ("Growing older is growing weaker").

The above conceptual model, although comprehensive, is clear and readily accounts for the complex nature of older people's experiences. This is thought to be an important feature as often CBT therapists unfamiliar to working with older people are vulnerable to feeling deskilled when working in the midst of such complexities. Such as, when working with a depressed older client, presenting with a range of physical illnesses, multiple loss experiences, and age related negative thoughts (such as "It is depressing to be old"). It is in the light of these challenges that cognitive therapists who work with older people need a specific age related conceptualization that integrates CBT interventions within a gerontological cognitive framework. The age stereotype of ageing equates this phase of life with decrepitude, and this needs to be addressed in order for a patient to challenge erroneous thinking that may prevent him from fully making changes in his life. Thus in applying CBT using this conceptualization, one challenges the age stereotype in a problem focused, specific and pragmatically oriented way, allowing older adults to get the maximal quality of life possible in their circumstances.

Acknowlegements

The authors wish to acknowledge the extremely helpful editorial suggestions made by Ian James on earlier drafts of the paper. We also wish to thank our anonymous reviewers.

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APPENDIX THREE:

PATIENT INFORMATION SHEET

Fife Primary Care
NHS TRUST

LATE LIFE DEPRESSION PROJECT

PATIENT INFORMATION SHEET

We would like to invite you to take part in a study that compares a psychological (talking) treatment with standard treatment for depression. We are interested in finding out if the two treatments are equal in helping people overcome depression or if one might be better. For adults under 60 years of age, we know that both treatments are successful treatments for depression. We do not know the answer to this for adults over 60 years old and this is the reason for the study.

In this study, ***everyone*** will be offered treatment for his or her depression. The treatment you receive will be selected at random, that is, we do not know which treatment you will receive. If you are given psychological treatment, *cognitive therapy,* you will receive up to a maximum of 20 sessions of treatment lasting one hour each over 18 weeks. The course of treatment may be shorter and this will depend on your individual circumstances. If you are given *standard treatment* you will receive the treatment you would normally have received. This may involve medication given by your doctor in the community or you may receive outpatient treatment which may also involve medication and regular follow-up.

random
us
blind

Approximately half of the patients will have their treatment sessions with the therapist audiotaped. This is to ensure that the therapist is doing the treatment correctly. These audiotapes are confidential and will only be listened to by professional staff involved in the study, after which they will be destroyed.

We will ask you to take part in a series of four interviews at the beginning and end of treatment and at two points after treatment has finished: at three months and six months. These interviews will take about one and a half hours and during this time you will be asked to complete some questionnaires. We also ask permission to collect information about your health service contacts from your general practitioner's records.

All information related to the study you give us, either during treatment or at any of the assessment interviews is **confidential.** We can visit you in your home if you have difficulty travelling to assessment appointments.

You are free to participate in this study but you can change your mind at any time and withdraw from the study. **This will not alter your care and treatment in any way**.

THANK YOU

APPENDIX FOUR:

PATIENT CONSENT FORM

LATE LIFE DEPRESSION PROJECT

PATIENT CONSENT FORM

To be completed by patient

I have read the information sheet and understand it	**Yes/No**
I have a copy of the information sheet which I can keep	**Yes/No**
I have had an opportunity to discuss the study with the researcher and to ask questions	**Yes/No**
I am satisfied with the answers I have received about the study	**Yes/No**
I understand that I am free to withdraw from the study at any time, without having to give a reason, and that this will not affect my treatment	**Yes/No**
I am satisfied that the information I give will be confidential	**Yes/no**
I agree that my GP records may be consulted during the time of the study	**Yes/No**
I agree to take part in this study	**Yes/No**

My Name:
Date:

We ask that someone independent of the study witnesses your signature

Witness:

APPENDIX FIVE:

LETTERS OF ETHICAL APPROVAL

FIFE HEALTH BOARD

Springfield House
Cupar
Fife
KY15 5UP

Tel: (01334) 656200
Fax: (01334) 652210
Text: 0345 626799

Your Ref:
Our Ref: DE/JG/Ethics/Letters/13049922
Enquiries to: Mr D. Elder
Ext: 332
Dept Fax: 01334 652210
E-Mail: -

20 April 1999

Mr K. Laidlaw
Fife Primary Care NHS Trust
Stratheden Hospital
Department of Clinical Psychology
CUPAR

Dear Mr Laidlaw

A RANDOMISED, CONTROLLED TRIAL OF COGNITIVE BEAHAVIOUR THERAPY VERSUS TREATMENT AS USUAL IN THE TREATMENT OF MILD TO MODERATE LATE LIFE DEPRESSION

I refer to your application to the Fife Local Research Ethics Committee for the above study.

I write to confirm that the Fife Local Research Ethics Committee at its meeting on 13 April 1999 approved the application.

The remit of the Committee requires that they follow up projects they have approved to determine the success or otherwise of such studies.

I would be pleased, therefore, if you would provide a copy of any final reports produced as a result of your study or alternatively to receive from you written confirmation of the results of your study for submission to the Committee.

Yours sincerely

MR D ELDER
Secretary
Fife Local Research Ethics Committee

c.c. Mr H. L. Toner, Clinical Psychologist, Stratheden Hospital, Cupar
Dr S. Clark, Psychiatrist, Stratheden Hospital, Cupar

GREATER GLASGOW PRIMARY CARE NHS TRUST

Administrator Research Ethics Committee:
Mrs Anne McMahon

AMC

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Dr K Davidson
Consultant Clinical Psychologist
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1055 Gt Western Road
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G12 0XH

28 May 1999

Dear Dr Davidson

PROJECT: ***A randomised controlled trial of cognitive behaviour therapy versus treatment as usual in the treatment of mild to moderate late life depression***

Thank you for sending the required amendments to this submission. I am pleased to be able to tell you that the Committee now has no objections from an ethical point of view, to this project proceeding and ethical approval is formally granted. You will know that you should also inform the Research & Development Directorate.

I would also like to take this opportunity to remind you that you should notify the Committee if there are any changes, or untoward developments, connected with the study – the Committee would then require to further reconsider your application for approval. The Committee would be grateful if a brief final report on your project could be forwarded to the Committee when the project reaches its conclusion.

May I wish you every success with your study.

Yours sincerely

Anne McMahon

ANNE W McMAHON
Administrator – Research Ethics Committee

cc B Rae

GREATER GLASGOW PRIMARY CARE NHS TRUST

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Dr Kate M Davidson
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25 May 1999

Dear Dr Davidson

PROJECT: ***A randomised controlled trial of cognitive behaviour therapy versus treatment as usual in the treatment of mild to moderate late life depression***

Thank you for sending this submission to the Research Ethics Committee – it was debated at the meeting on Thursday, 13 May 1999. I am sorry to let you know that ethical approval was not granted at this time. There were various amendments that require to be carried out.

It was the view of the Committee that the title of the Patient Information Sheet be altered to "CBT versus standard treatment", as this perhaps would seem more user friendly. The Committee would also request that it be made more explicit in the fourth paragraph exactly how many interviews the patient will be involved in e.g. 6 interviews? and that the word "short" in the first sentence be altered to "*series*". It was also felt appropriate that the first sentence of the 6th paragraph should read "You are free to *participate in this study*....."

In the consent form the Committee would request that an insertion be made to indicate that you would be consulting GP records.

We would also be grateful to see a copy of the letter to the GP and also Appendix 1.

On a further point it would be helpful if you could clarify what is meant by BTU and TAU and exactly how variable TAU is. We would also be grateful if you could elaborate on the exclusion criteria.
Yours sincerely ,

I hope these comments are helpful and look forward to receiving the required amendments.

Yours sincerely,

Anne McMahon

ANNE W McMAHON
Administrator – Research Ethics Committee

cc B Rae

APPENDIX TWO:

CORRESPONDENCE WITH CSO

THE SCOTTISH OFFICE

Department of Health

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

Telephone 0131-244 2254
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Dr K Laidlaw
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Stratheden Hospital
CUPAR
Fife KY15 5RR

Our Ref: OOR/2/26(17/98)

11 March 1998

Dear Dr Laidlaw

A Randomised Control Trial of Cognitive Therapy versus Treatment as Usual in Late Life Depression

I have now received comments on your outline proposal on the above topic. The view of the assessors is that you should resubmit an outline proposal with modifications to take account of the following points.

1. Is it possible to include an untreated control group in addition to the treatment as usual and cognitive therapy groups?

2. The statistical power calculation does not give details of the outcome difference considered to be clinically relevant. It is suggested that a pilot study might be helpful in ensuring relevant power calculations can be made.

3. The study should contain an element of cost benefit analysis.

4. It would be helpful to include a measure of general functions specifically designed for use in the elderly, together with a carer's or relative's view of patient's state.

I hope you find these comments helpful and I look forward to hearing from you.

Yours sincerely

JOHN DUFFY
Research Manager
Chief Scientist Office

BMA17fol

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or direct dial 0131 537 6277

John Duffy
Research Manager
Chief Scientist Office
NHS Management Executive
St Andrews House
Edinburgh, EH1 3DG

20th June 1998

Dear Mr. Duffy,

A Randomised Control Trial of Cognitive Therapy plus Treatment as Usual versus Treatment as Usual in Late Life Depression.

Thank you for returning our project proposal outline so promptly and for sending the reviewers' comments. We have considered these very carefully. We will deal with each comment separately and have indicated where changes have been made in the revised proposal outline (enclosed).

1. Including an untreated control group in addition to the groups proposed.
On the assumption that the referees suggested an untreated control group as a means of controlling for spontaneous remission in either active treatment group, there is strong research evidence (Thompson *et al*, 1987)[1] to suggest that this is unlikely, as these researchers used a delayed treatment condition in their studies and have consistently reported no change across the delayed wait list control condition.

In informal discussion with our local ethics committees we have formed the impression that an untreated control group would be considered less acceptable. In addition, it would be difficult for patients suffering from depression to remain untreated and it is likely that we would have very little influence over GP prescribing for this group. This could result in a contaminated group. We also believe that patients are less likely to volunteer to take part in a study for depression which may leave them untreated for a period of time.

2. The statistical power calculation does not give details of the outcome difference considered to be clinically relevant...
We are grateful for the helpful comments with regard to this issue. Full details of changes to

---

[1] Thomson, L.W., Gallagher-Thompson, D. & Breckenridge, J. (1987) Comparative effectiveness of psychotherapies for depressed elders. *J.Consult. Clin. Psychol.* **55**: 385-390

our power analysis are contained within the *determination of sample size* subsection of the methodology section of our revised outline submission.

3. The study should contain an element of cost benefit analysis.
We have considered this point carefully and are in agreement with the reviewers as to the importance of this point. Amendments with regard to this matter are contained within the *measures* subsection of the methodology section of our revised outline submission .

done?

4. It would be helpful to include a measure of general functions specifically designed for use with the elderly, together with carers' or relatives' view of patients' state.
We also consider this an important point. We agree it would be useful to include a measure of carer burden. The measures which we have included are designed for use with older adults.

Changes to research methodology
Although we would prefer to evaluate the efficacy of cognitive behaviour therapy (CBT) alone versus treatment as usual (TAU), our further discussions with psychiatrists and GPs have indicated that they may be reluctant to refer patients to a study evaluating CBT versus TAU. We have therefore made a substantive change to the design of our study and rather than evaluating CBT alone versus TAU alone for depression in older adults we have decided to evaluate the comparative efficacy of CBT as an adjunctive treatment. By making this change we believe we can ensure recruitment of participants. If you have any comments on this matter we would be very grateful.

I trust that we have answered the comments of your reviewers and trust that these revisions to our project proposal outline are satisfactory.

Yours sincerely

K. Laid

Ken Laidlaw
Chartered Clinical Psychologist
Principal investigator (Fife)

Dr. Kate Davidson
Consultant Clinical Psychologist
Principal investigator (Glasgow)

THE SCOTTISH OFFICE

Department of Health

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

Telephone 0131-244 2254
Fax 0131-244 ~~2323~~ 2285

Dr K Laidlaw
Department of Clinical Psychology
Stratheden Hospital
CUPAR
Fife KY15 5RR

Our Ref: OOR/2/26(R17/98)

10 July 1998

Dear Dr Laidlaw

A Randomised Control Trial of Cognitive Therapy plus Treatment as Usual versus Treatment as Usual in Late Life Depression

I have now received the assessors' reports on your outline application on the above topic. You will be pleased to hear that they recommend that you proceed to a full grant application.

In preparing your submission you may wish to bear in mind the following points:

- power calculations should be based on a robust estimate of the additional effect of CBT, justified either by reference to the literature or direct experience
- how will the assessors of outcome be blinded to the treatment regime?

I hope you find these comments helpful and I look forward to receiving your full application in due course. For your convenience I enclose a form for the nomination of referees.

Yours sincerely

JOHN DUFFY
Research Manager
Chief Scientist Office

BMA17fol

THE SCOTTISH OFFICE

Department of Health

NHS Management
Executive
St. Andrew's House
Edinburgh EH1 3DG

Telephone 0131-244 2077
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Mr K Laidlaw
Department of Psychiatry
Kennedy Tower
Royal Edinburgh Hospital
Morningside Park
EDINBURGH EH10 5HF

3 November 1998

Dear Mr Laidlaw

Ref 6/13 - A Randomised Control Trial of Cognitive Behavioural Therapy plus Treatment as Usual versus Treatment as Usual Alone in the Treatment of Late Life Depression

The above application was considered at the meeting of the Health Services Research Committee held on 28 October. I regret to inform you that the Committee were unable to recommend funding of this project in its current form. However they would be willing to consider a resubmission of this proposal without any commitment to fund.

The Committee felt this was a potentially important study but had a number of concerns about the design. These were:

- it should be practical and it would certainly be more valuable to compare treatment as usual with cognitive behavioural therapy
- TAU should be exactly that and should not be constrained for the purposes of the study
- patients with a history of non-response to psychological treatment should not be excluded unless those who do not respond to pharmacotherapy are also excluded, but ideally both should be included
- more should be done to ensure that CBT is delivered in a standardised way
- intention to treat is interpreted in too restricted a way. Outcome measures should be sought for all those who begin treatment rather than assuming that those who discontinue treatment have relapsed
- more needs to be done to ensure the blindness of assessors; alternatively the assumption of blindness should be dropped
- a large number of tests are proposed. This should be reconsidered with a view to limiting the burden on respondents

- the total funding sought, excluding indirect costs, exceeds our limit of £125,000 so savings must be found, for example in the amount of equipment and secretarial support sought. It is not clear why laptop computers are needed nor why 4 tape recorders are needed since only a sample of therapy sessions will be tape recorded

- on the other hand, it is not clear how the economic evaluation will be carried out and some specialist economic input to the cost benefit analysis should be included.

I enclose copies of referees' comments which you may also find useful. The deadline for proposals for the next Committee meeting is 4 December, and I look forward to receiving a revised proposal.

Yours sincerely

Peter Craig

DR PETER CRAIG
Research Manager
Chief Scientist Office

cc Dr K M Davidson
Mr H Toner

December 3rd 1998

DEPARTMENT *of* PSYCHIATRY

The University of Edinburgh
Kennedy Tower
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Dr. Peter Craig
Research Manager
Chief Scientist Office
(Health Services Research)
NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

Dear Dr. Craig

Ref 6/13 - A RANDOMISED CONTROLLED TRIAL OF COGNITIVE BEHAVIOURAL THERAPY VERSUS TREATMENT AS USUAL ALONE IN THE TREATMENT OF MILD TO MODERATE LATE LIFE DEPRESSION.

Thank you for your letter dated 3 November 1998. I enclose a revised grant submission. We are grateful to you for sending us the reviewers' comments which we found constructive and helpful. We have considered each point carefully and will deal with each separately below.

- **It should be practical and it would certainly be more valuable to compare treatment as usual with cognitive behavioural therapy.**

We agree with the reviewers that it would be more valuable to compare cognitive behavioural therapy alone vs treatment as usual alone. You may recall that originally our psychiatric colleagues expressed some reservations about referring patients for cognitive behavioural therapy alone. In light of the reviewers comments, the research group (which includes our psychiatric colleagues) have agreed that this change to our study design is acceptable providing we restrict our recruitment to those participants with mild to moderate late life depression.

- **Treatment as usual should be exactly that and should not be constrained...**

We agree that treatment as usual should be treatment that people would normally receive and have therefore amended our definition. Full details of the amendment are included in the section of our proposal entitled *TAU alone*.

- **Patients with a history of non-response to psychological treatment should not be excluded....**

We agree with the reviewers on this issue. We have therefore amended our inclusion and exclusion criteria to allow a more equal comparison. We therefore will not exclude previous non-responders to either treatment conditions.

- **More should be done to ensure CBT is delivered in a standardised way**

We have taken this point into account and have made some changes to the section of our proposal entitled *CBT treatment integrity assessment.* We shall ensure that all CBT therapists on the trial receive three days of intensive training in the delivery of CBT for late life depression and regular supervision throughout the trial. In addition treatment fidelity will be evaluated through a sample of audiotaped.sessions.

- **Intention to treat is interpreted in too restricted a way.**

We agree with the reviewers on this issue. Full details of the changes are included in the section of our proposal entitled *data processing and analysis.* We decided that participants who attend for at least one session of active treatment will be included and reported in our outcome analyses. With their permission, we will also make attempts to follow up these participants and include their data in our final outcome analyses

- **More needs to be done to ensure the blindness of assessors....**

We have considered this point carefully. We include full details of the changes in the section of our proposal entitled *Randomisation procedure.* To ensure that our research assistants remain blind to treatment condition, they will have no contact with participants during the active treatment phase of the trial. They will meet participants *prior* to randomisation and then at end of active treatment and during follow-up. During follow-up we will attempt to maintain blindness by not discussing information that could identify patient treatment group.

- **A large number of tests are proposed...**

We have reduced the number of tests and consequently the burden on participants in this proposed treatment trial.

- **The total funding sought, excluding indirect costs exceeds our limit of £125 000 so savings must be found...**

We have reduced the costs on this grant application and this no longer exceeds your limit. You will note that the main cost saving has been to remove the formal input from medical statistics. In regard to the costing of equipment generally, if this grant was awarded we would look for the best deal available.

- **It is not clear how the economic evaluation will be carried out...**

More details of our economic evaluation are included in the section of our proposal entitled *Cost-Benefit Analyses.* We are in the process of seeking advice from a health economist.

We trust that we have answered your concerns. We look forward to hearing from you.

Yours sincerely

Ken Laidlaw
Chartered Clinical Psychologist
/ Lecturer in Clinical Psychology
Principal applicant

Dr. Kate Davidson
Consultant Clinical Psychologist
Co-applicant

Form 2

Chief Scientist Office - Application form for project grant

1. Application for a research grant in: *(please tick)*

Biomedical & Therapeutic Research (full grant)	
Health Services Research (full grant)	✓
Health Services Research (mini-grant)	

2. *(please tick)*

New project	
Re-submission	✓
Supplementary funding	

3.

Project title *(not more than 25 words)* **A Randomised Control Trial of Cognitive Behavioural Therapy plus Treatment as Usual versus Treatment as Usual Alone in the Treatment of Late Life Depression**

4.

Proposed start date	April 1999
Proposed finish date	March 2002

5. Summary of costs:

Staff	Indirect costs *(if applicable)*	Equipment	Consum-ables	Travel	Other	**Total**
95,904	**38,361**	**5,572**	**6,300**	**7,395**	**11,055**	**164,587**

NHS support costs	**64, 892**

6. Applicants' details:

Title and full name *(Principal applicant)*	**Mr. Kenneth Laidlaw**		
Full address	**Department of Psychiatry** **The University of Edinburgh** **Kennedy Tower** **Royal Edinburgh Hospital** **Morningside Park** **Edinburgh EH10 5HF**		
Telephone no/ext **0131 537 6277**	Fax no **0131 447 6860**	E-Mail code **k.laidlaw@ed.ac.uk**	Hours per week **20**
Organisation **University of Edinburgh**	Department **Psychiatry**	Position **Chartered Clinical Psychologist/ Lecturer in Clinical Psychology**	

Title and full name *(Co- applicant)*	**Dr. Kate M. Davidson**		
Full address	**Department of Psychological Medicine** **Greater Glasgow Community & Mental Health Services NHS Trust** **Gartnavel Royal Hospital** **1055 Great Western Road** **Glasgow G12 0XH**		
Telephone no/ext **0141 201 3920**	Fax no **0141 357 4899**	E-Mail code **k.davidson@clinmed.gla.ac.uk**	Hours per week **20**
Organisation **University of Glasgow/ Greater Glasgow Community & Mental Health Services NHS Trust**	Department **Psychological Medicine**	Position **Consultant ClinicalPsychologist/ Research Tutor**	

Title and full name *(Co-applicant)*	**Mr. Hugh L. Toner**		
Full address	**Department of Clinical Psychology** **Fife Healthcare NHS Trust** **Stratheden Hospital** **Cupar** **Fife KY15 5RR**		
Telephone no/ext **01334 652611 ext 334**	Fax no **01334 655380**	E-Mail code	Hours per week **40**
Organisation **Fife Healthcare NHS Trust**	Department **Clinical Psychology**	Position **Area Head of Service**	

7. Ethical approval, confidentiality, data protection and animals:

Attached	Currently Being Sought	Not required		Requested	✓Being Sought

8. Support:

This application has been submitted in the past year to:
N/A
This application is currently being submitted to:
CSO ONLY
Other research grants currently held *(organisation, project title, funding and period of support)*:
Dr. Kate Davidson: Prevention of ParasuicideTrial; MRC Funded; Three years support.
Is there any overlap between this application and the other grants which you hold or are applying for? *(organisation, project title, funding and period of support)*:
NO

9. Commercial exploitation:

Is the proposed research likely to lead to patentable or other commercially exploitable results? *(please give details)*
NO

10. Financial support requested:

Chief Scientist Office

	Financial year (1 April - 31 March)				
	Year 1	Year 2	Year 3	Year 4	Total
Staff	30,908	31,956	33,040	-	95,904
Indirect costs	***12,363***	***12,782***	***13,216***	-	***38,361***
Equipment	5,572	-	-	-	5,572
Consumables	2,695	1,955	1,650	-	6,300
Travel	2,465	2,465	2,465	-	7,395
Other	6,885	585	3,585	-	11,055
Total	60,888	49,743	53,956		164,587

NHS support costs

	Financial year (1 April - 31 March)				
	Year 1	Year 2	Year 3	Year 4	Total
Service support					
Blood tests, X-rays, etc					
In-patient stays					
Extra nursing					
Other *(please specify)* *Excess Treatment Costs** Additional CBT therapists (Clin.Psychol or equivalent) to provide CBT treatment to ensure a sufficient sample of patients within the research period	11,250	15,000	3, 750 (for 6 months only, at half time)		30,000
Infrastructure					
R & D offices (peer review)					
Replacement of clinician time to allow R & D by KL, KD and HT @ 0.1WTE each,	11,396	11,616	11,880	-	34,892
Purchase/hire of equipment					
Employment of additional staff					
Total	22,646	26,616	15,630		64,892

* Standard psychological treatment costs are approximately £400. The extended treatment involved in CBT for late life depression is expected to cost £600 per patient. It is considered that additional costs (excess treatment costs) are fifty (50) patients spread over three years and across two treatment centres.

11. Declaration and authorisation:

Applicants: ***I have read the standard conditions of grant set out in the "SODoH-CSO-Research Grants" and agree to abide by them and any amendments which may subsequently be issued. To my knowledge the project described here represents the ideas, concepts and writings of myself and co-investigators and is not a modification of projects submitted by others elsewhere.***

Signature of applicants	Name (Capitals)	Date
K. Laidlaw	K. LAIDLAW	27th August 1998
K.M. Davidson	K.M. DAVIDSON	30th August 1998
Hugh C Toner	HL TONER	27th Aug. 1998

This application should be submitted by/through (i) the Head of Department and (ii) the officer who will be responsible for administering any grant that may be awarded. Each should be asked to complete the following declaration:

I confirm that I have read this application and that, if successful, the work will be accommodated and administered in this Department/Institution. The staff gradings and salaries proposed are correct and in accordance with the normal practice of this Institution. I accept responsibility for the conduct of this project and funds awarded for it and shall immediately inform the Chief Scientist Office if there is any indication of scientific misconduct or misuse of grant funds.

Head of Department:

Signature Eve C Johnstone	Date 27/8/98
Title and full name (block capitals) PROFESSOR EVE C JOHNSTONE	Department PSYCHIATRY

Administering Institution:

Signature Lorraine Kellacher	Date 31 August 1998
Title and full name (block capitals) LORRAINE KELLACHER	Position held ADMINISTRATIVE OFFICER
Address EDINBURGH RESEARCH & INNOVATION 15 SOUTH COLLEGE STREET, EDINBURGH	Postcode EH 8 9AA
Telephone no/ext 0131 650 9032	Fax no 0131 650 9019

12. Project summary: *(150 words)*

Depression is the most common psychiatric disorder amongst older adults and is associated with a high risk of suicide. The consensus is that older adults with depression are likely to have an increasing risk of subsequent relapse yet evidence suggests that gains made with psychological treatments are maintained at prolonged follow up and that cognitive behavioural therapy (CBT) may have a prophylactic value in terms of protecting patients from further episodes of depression.

Currently there is a need for a definitive and systematic study investigating the clinical effectiveness of this treatment approach. The present study is the first UK evaluation of individual CBT for late life depression. The study investigates whether CBT plus pharmacotherapy produces greater improvement than pharmacotherapy alone at the end of active treatment and investigates whether combined treatment results in a lower risk of relapse/ at one year follow-up and in lower attrition rates during active treatment.

TITLE

A Randomised Control Trial of Cognitive Behavioural Therapy plus Treatment as Usual versus Treatment as Usual Alone in the Treatment of Late Life Depression

INTRODUCTION

Demographic changes in the late 20th century are marked by the increasing proportion of people in the western world who survive into old age. It is estimated that by 2020 there will be twice as many people aged 60 and above living in the European Community than there were in 1960. Depression is the most common psychiatric disorder amongst older adults. Prevalence studies consistently indicate symptoms of depression occurring in up to 15 per cent of adults resident in the community aged 65 years and above[1]. Late life depression is associated with a high risk of suicide[2] with drug overdose the most favoured method[3]. Additionally there is evidence that depression is associated with an increased mortality rate amongst older adults[4]. Low expectations regarding treatment success and a fear of possible negative side-effects from antidepressant medication, often leads to a high incidence of prescriptions of subtherapeutic dosages[5]. It is often erroneously presumed that depression is a natural consequence of the losses associated with the ageing process. Therefore treatments with recognised efficacy, such as cognitive behavioural therapy (CBT), which are widely available to those under the age of 65 are not recognised as viable options for older adults with depression.

For late life depression, alternative non-pharmacological treatment approaches are necessary. People are often reluctant to take medication and very often favour psychosocial approaches instead[6]. The consensus is that older adults with depression are likely to have an increasing risk of subsequent relapse[7] yet evidence suggests that gains made with psychological treatment are maintained at prolonged follow up[8] and that CBT may have a prophylactic value in terms of protecting patients from further episodes of depression[9]. There is likely to be a difference in attrition rates[9-10] with CBT being better tolerated than TAU because of less evidence of side effects. CBT might therefore be a preferred treatment for late life depression especially in view of the risks of overdose in depressed older adults[2-3].

Meta-analytic reviews of outcome research into psychological treatments for depression in older adults have generally reported favourable results[11-12], with broadly defined psychological treatments being evaluated as reliably more effective than placebo or no treatment conditions.

Much of the evidence for the efficacy of individual CBT for depression in older adults has been provided by one research group in North America[8, 13]. The generalisability of results from this group to a UK clinical population is however questionable for a number of reasons, including, differences in cultural and health-care delivery systems and the fact that the American groups are generally in good physical health with sufficient emotional and economic resources to seek alternative help for their depression. Since most depressed older adults suffer from at least one comorbid physical condition[1] the effectiveness and applicability of CBT can be more meaningfully evaluated with a representative sample of the population of depressed older adults. Currently there is a need for a more definitive and systematic study investigating the clinical effectiveness of this treatment approach[14]. The present study aims to address the above issues by setting up the first UK evaluation of individual CBT for late life depression. The aim is to compare the efficacy of CBT in combination with treatment as usual versus treatment as usual (TAU) alone, generally pharmacotherapy, in late life depression both at the end of active treatment and during 6 month follow-up.

RESULTS OF PILOT STUDY

The referral and treatment decision process used by GPs for older adults with mental health problems in Fife was investigated[15]. Of the GP practices sampled, we estimate GPs are diagnosing and treating depression in 5 - 10 per cent of their over 65 population. Treatment appears to mainly consist of pharmacotherapy, although a majority of GPs include at least some form of psychosocial support for older

adults. Most treatment is discontinued early with very few GPs appearing to continue treatment for up to 6 months post recovery in line with consensus guidelines. The majority of GPs stated a willingness to refer older adults to specialist older adults clinical psychology services.

AIMS OF RESEARCH STUDY

The study investigates whether CBT plus TAU, generally pharmacotherapy, produces greater improvement in depressive symptomatology and lower attrition rates during active treatment than TAU alone. The study will also investigate whether combined treatment (CBT + TAU) results in lower levels of depressive symptomatology, and in a lower risk of relapse/recurrence (strictly defined)[16] than TAU alone during 6 month follow-up.

RESEARCH QUESTIONS

A. End of active treatment phase

i. Compared to TAU alone, does CBT + TAU for late life depression produce significantly lower levels of depressive symptomatology?

ii. Compared to TAU alone, does CBT + TAU for late life depression produce significantly lower attrition rates and is it perceived as a more acceptable treatment for depressed participants?

B. Follow-up phase

iii. Compared to TAU alone, does CBT + TAU produce significantly lower levels of depressive symptomatology during 6 month follow up?

iv. Compared to TAU alone, does CBT + TAU produce significant differences in rates of *strictly defined* relapse and recurrence during 6 month follow-up?

PLAN/METHODOLOGY

Participants: Non-urgent out-patient and day-patient referrals to Clinical Psychology and Psychiatric services. Subjects will recruited from two sites: Fife and Glasgow. Participants must satisfy the following inclusion criteria:

1. Be aged between 60 - 85 years.
2. Achieve primary diagnosis of depression using DSM IV diagnostic criteria for Major Depressive Disorder.
3. Have Geriatric Depression Rating Scale scores of 11 and above, and Beck Depression Inventory (BDI) scores of 16 and above.
4. Able to give written informed consent.

Participants will be excluded from the trial using the following criteria:

1. Insufficient knowledge of English to enable them to be assessed adequately and to satisfactorily provide written informed consent to treatment.
2. Participants exhibiting psychotic features, evidence of organic pathology (MMSE <22) or currently undergoing ECT for late life depression.
3. Participants with a previous history of non-response to psychological treatment for depression.

Procedure: Suitable referrals to psychiatric and psychological services over an eighteen month recruitment period will be contacted by letter by the researchers and invited to take part in a screening interview (administered by psychology research assistant) for inclusion in the treatment trial. Those participants who meet the inclusion criteria (see above) and who agree to give written informed consent to take part in the study will be offered an appointment with the research assistant in order to complete baseline measures outlined below. Participants will then be randomly allocated to either one of *two* active treatment groups namely: CBT plus TAU, or TAU alone.

Treatment conditions

TAU alone

In this treatment condition each participant will be interviewed by a Consultant Psychiatrist who will then provide advice to participants' General Practitioners on acceptable ranges of medication and therapeutic dosages for the treatment of depression in each case. TAU requires that the actual management of

depression is carried out in the community by GPs using standard service delivery models which may include involvement of CPN and other mental health services as individual circumstances dictate. Participants referred to CPN services as part of their TAU component of treatment (either TAU alone or in combination with CBT), will not receive cognitive and behavioural interventions from CPNs. Participants receiving TAU alone will have contact with the research assistants only at time of screening and at reassessment.

CBT plus TAU

In addition to TAU (outlined above) participants randomly allocated to this group will receive up to 20 sessions (spread over a 6 month period) of cognitive behavioural therapy for late life depression. At start of treatment each participant will attend for CBT weekly for the first four weeks and thereafter either weekly or fortnightly for a minimum of 8 sessions and a maximum of up to 20 sessions as appropriate. Participants receiving CBT plus TAU will have contact with the research assistants only at time of screening and at reassessment.

CBT treatment integrity assessment

To ensure therapists adhere to treatment protocols a random sample of sessions will be audiotaped and rated by KMD using the Cognitive Therapy Rating Scale.

Justification for Study Design

Although our preference is to evaluate the efficacy of CBT alone versus TAU alone, our further discussions with psychiatrists and GPs have indicated that they would be reluctant to refer patients to a study evaluating CBT versus TAU. We have therefore decided to evaluate CBT plus TAU versus TAU alone for the treatment of depression in older adults. Thus we are evaluating the comparative efficacy of CBT as an adjunctive treatment. By choosing this design we believe we can ensure recruitment of participants.

Randomisation procedure: This will be overseen by the Medical Statistician (AC) who is not involved in the clinical aspects of the trial. One secretary at one of the treatment centres will be responsible for the implementation of the randomisation procedure. To ensure that the research assistants remain blind to treatment allocation they will have no contact with participants during the active treatment phase of the trial. The research assistant will see each participant five times, once before allocation to treatment group, at baseline, again at the end of treatment and twice during the six month follow-up phase of treatment.

Determining sample size: Power calculations are based upon a study investigating the effectiveness of group cognitive therapy plus medication versus medication alone for late life depression[10] which reported scores on the Beck Depression Inventory at three months follow-up. Using two-tailed significance levels, 90 per cent power and a type I error of .05, the smallest sample size required is 56 participants in each treatment condition. Assuming a 30 per cent drop out rate between screening and patients completing treatment, this study is considered to require 150 patients in total.

Measures

Primary clinical outcome will be determined by :

Semi-structured interview based ratings by assessors blind to treatment condition.

At baseline and at 6 month follow-up all participants will be assessed using the SCID to determine diagnostic status. Time free of depression and depression symptom state will be assessed at 3 and 6 month follow up using the longitudinal interval follow-up evaluation (LIFE)[17].

Self- and observer-report measures

At baseline, end of treatment and during 6 month follow-up, clinical global symptom severity (CGSS) and clinical global improvement (CGI) will be recorded. In addition at these interview points quality of life will be assessed using the WHOQOL-BREF, a 26 item questionnaire measuring four important dimensions of quality of life such as physical health, psychological, social relationships and environment. The Beck Depression Inventory (21 item) and Beck Anxiety Inventory will be administered during the screening stage, at baseline, during treatment, end of treatment and during 6 month follow-up. Observer report measures will include the 30 item Geriatric Depression Scale and therapist rated CGSS and CGI.

Measures of cognitive functioning:

Given that the effect of depression on cognition in later life is not yet fully understood it is proposed to include some measure of cognitive functioning of individuals at the start and end of treatment. Measures will include NART (1 time only), Benton Visual Retention Test (BVRT) and the MMSE.

Cost-benefit analyses

Full assessment of direct and indirect costs of health service utilisation[18] will be made in each groups both during active treatment and at 1 year follow-up. Costs considered will include medication prescriptions and changes, courses of ECT, visits to GP, measurement of carer stress, emergency and routine hospital admissions, referral to social services, take-up of long-term residential care placements and admissions to psychiatric day hospitals.

Schedule of assessment procedures

Measures	Screening	baseline	8 weeks	16 weeks	Endpoint	3 mth Follow-up	6 mth Follow-up
SCID	yes						yes
LIFE						yes	yes
CGSS		yes			yes	yes	yes
CGI		yes			yes	yes	yes
QOL-BRF		yes			yes	yes	yes
BDI	yes	yes	yes	yes	yes	yes	yes
BAI		yes			yes	yes	yes
GDS	yes	yes	yes	yes	yes	yes	yes
NART	yes						
MMSE	yes				yes	yes	yes
BVRT	yes				yes	yes	yes

Data processing and analysis: Over the course of the trial, statistical advice and consultation will be available from Alan Clark, Medical Statistician at Gartnavel Royal Hospital. The primary outcome measure of efficacy will be level of severity of depressive symptoms. Other outcome measures of efficacy will be the proportion of participants in each group who at 6 months meet strictly defined criteria for relapse. To check the balance at baseline between the combined treatment (CBT + TAU) and conventional treatment (TAU alone) the distribution of characteristics will be investigated[19]. For the categorical outcomes intention to treat analyses will be adopted and participants who terminate treatment prematurely and who attend for at least two months of active treatment will be included in our analyses. These patients will be assumed to have relapsed for the purposes of analysis. For continous measures of outcome differences between treatment groups will be analysed initially using t-tests. The differences between the groups will then be estimated by conventional 95 per cent confidence intervals (CI) for the mean treatment difference. Differences in relapse rates between the treatment groups at six months follow-up will be analysed by chi-square test for independent samples.

TIMETABLE OF WORK

Stage one: Preparation of CBT manuals, trial planning and therapist training

Over the first three months of the project, time will be allocated to producing CBT therapist and self-help manuals based upon Thompson and colleagues [20-21]. Psychology research assistants will be recruited and trained at this stage. The Medical Statistician will create the project databases and develop and test out the randomisation procedure during this phase.

Stage two: Recruitment and active treatment phase and end-point data-analysis

Recruitment of participants into the trial will begin on the fourth month, and will cease after 18 months (21 months after the study begins). Allowing a further six-months for treatment for participants recruited at this final stage, all active treatment will cease after 27 months (23 months of recruitment and treatment). With a six-month follow-up phase, data collection will cease at 33 months.

Stage three: data-analysis, research write-up and submission of final report

Three months is required for data analysis and for preparation of the final report to the CSO. During this time manuscripts will be prepared and submitted to relevant journals for publication.

Therapist workload and assumed recruitment rate per month

Over the active treatment stage this project requires each centre to recruit 75 participants. Recruitment will take place over 18 months, therefore each site requires to recruit 3-4 depressed older adults per month or 1 per week. Thus a referral rate of 1 participant for each group is needed per two week period.

Timetable of phases of treatment trial

Phase one: preparation time 3 months----------	Phase two: Recruitment & treatment 18 months----------	Phase three: treatment cont. 6 months-------	Phase four: 3 & 6m. Fllw-up 6 months----------	Phase five: Data analysis 3 months---------
start of trial	Overall: trial lasts 36 months			finish of trial

EXISTING FACILITIES

The project will be jointly based within the University of Edinburgh, Department of Psychiatry and the University of Glasgow, Department of Psychological Medicine where two of the proposed grant holders are members of staff. Clinical staff involved in the project are employed by Fife Healthcare NHS Trust and Community and Mental Health Services NHS Trust (Glasgow). In addition there are close links with psychiatric colleagues. We are also fortunate in having developed close links with eminent cognitive therapy researchers in America (Larry W. Thompson & Dolores Gallagher-Thompson).

JUSTIFICATION OF REQUIREMENTS

This proposal requires two full-time psychology research assistants (one for each site) on spine point 13 - 15, and two 0.2 WTE secretaries over three years. The research assistants' role will consist of carrying out initial screening interviews using structured measures outlined above. They will also administer baseline assessments using measures outlined above prior to randomisation of participants to treatment groups. Re-assessment using measures outlined above will also be conducted by the research assistants at the end of treatment and at the 3 month and 6 month follow-up points. They will also have responsibility for scoring and preparation of data for analysis as well as being responsible for liaison between the two centres of the trial. Much of the liaison will be conducted by electronic mail thus requiring budget allocation for the provision of two laptop computers with capability to allow this communication. To complete this research thoroughly will require substantial travel between sites for the two project managers (KL & KMD) co-ordinating smooth transition of the project over three years, resulting in a large budget allocated towards travel. The duties of the secretaries will be clerical and administrative; typing correspondence, managing appointments, co-ordinating data recording sheets, and checking compliance of therapist with treatment guidelines. One of the secretaries will have responsibility for the implementation of the randomisation procedure.

NHS IMPLEMENTATION POTENTIAL

Pharmacotherapy may not always be appropriate for depressed older adults. In addition research indicates poor compliance with medication regimes in the over 65 population[6]. Treatment alternatives need to be developed and systematically evaluated. Treatment approaches should be investigated not only in terms of efficacy of maintenance of gains but also effectiveness in terms of patient treatment acceptability within a UK sample drawn from a representative group of older adults suffering from depression. While cognitive-behavioural therapy may be costly in terms of therapist time and training, there may be longer term costs savings to be made if CBT can be shown to have a prophylactic value in terms of protecting patients from further episodes of depression by reducing relapse and recurrence rates for this disorder.

DISSEMINATION

Every effort will be made to ensure wide dissemination of results amongst clinicians responsible for the care and management of people suffering from late life depression. Given that this study will be the first UK evaluation of individual CBT for late life depression, it is envisaged that a large number of research reports will be developed for publication in geriatric and non-geriatric mental health journals. Presentation of results at appropriate conferences will also be conducted during and after the project.

KEY REFERENCES

1. Futterman, A., Thompson, L.W., Gallagher-Thompson, D., & Ferris, (1995) Depression in later life: Epidemiology, assessment, etiology and treatment, in, Beckham, E. E. & Leber, W. R. (eds.) *Handbook of depression,* Second edition, New York: The Guildford Press.
2. Hepple, J. & Quinton, C. (1997) One hundred cases of attempted suicide in the elderly. *British J. of Psychiatry,* **171:** 42-46
3. Draper, B. (1996) Editorial review: Attempted suicide in old age. *International Journal of Geriatric Psychiatry.* **11**: 577-587
4. Ames, D. (1994) Editorial: Why do the depressed elderly die? *International Journal of Geriatric Psychiatry.* **9**: 689-693
5. Heeren, T., Derksen, B, Heycop T., & Van Gent, P.(1997) Treatment, outcome and predictors of response in elderly depressed in-patients. *British J. of Psychiatry,* **170**: 436-440.
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16. Frank, E., Prien, R., Jarrett, R. B., Keller, M. B., Kupfer, D. J. *et al* (1991) Conceptulization and rationale for consensus definitions of terms in major depressive disorder. Remission, recovery, relapse and recurrence. *Archives of General Psychiatry,* **48:** 851-855
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18. Knapp, M.R.J., & Beecham, J. (1990) Costing mental health services. *Psychol. Med.* **20**: 893-908
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21. Dick, L. P., Gallagher-Thompson, D., Coon, D. W., Powers, D. V., & Thompson, L. W. (1995) *Cognitive-behavioral therapy for late life depression: A client manual*, Palo Alto, CA: Older Adult and Family Center, Veterens Affairs Palo Alto Health Care System.

RELEVANT ADDITIONAL INFORMATION

Details of financial support requested *Appendix 2 page 1*

Staff details

Name	Grade	Spine point	Incremental date	Starting salary £	Superann. + NI (combined) £	Total costs for a complete (notional) year £
(A1) Research staff						
Glasgow research assistant	Assistant Psychologist MH20	1	01/04/2000	12,630	2,652	15,282
Edinburgh (Fife) research assistant	Assistant Psychologist MH20	1	01/04/2000	12,630	2,652	15,282
Total				25,260	5,304	30,564
(B1) Technical staff						
Total						
(C1) Other staff						
TBA Glasgow	secretary A&C Grade 2	1	01/04/2000	9,576	NI 1,053	10,629
TBA Fife	secretary A&C Grade 2	1	01/04/2000	9,576	NI 1,053	10,629
Total				19,152	2,106	21,258

Details of financial support requested

Staff costs	*Effort on project*		*Financial year 1 April - 31 March*				
Annual costs of staff listed in Appendix 2 page 1	%	months	Year 1 £	Year 2 £	Year 3 £	Year 4 £	Total £
(A2) Research staff							
Fife (Edin) Research Assistant Psychologist	85	36	13,285	13,744	14,219	-	41,248
Glasgow Research Assistant Psychologist	85	36	13,285	13,744	14,219	-	41,248
			26,570	27,488	28,438		82,496
(B2) Technical staff							
(C2) Other staff							
Glasgow Secretary	20%	36	2,169	2,234	2,301	-	6,704
Fife Secretary	20%	36	2,169	2,234	2,301	-	6,704
							13,408
Total annual costs (A2+B2+C2)			30,908	31,956	33,040		95,904

Consumables Please specify details of items applied for	*Effort on project*		*Financial year 1 April - 31 March*				
	%	months	Year 1 £	Year 2 £	Year 3 £	Year 4 £	Total £
Test Materials (including BAI, BDI, GDS, NART, BVRT, SCID manuals and scoring sheets)			1,445	855	0	-	2,300
Stationery, computer discs and printer cartridges			250	100	150	-	500
Photocopying and inter-library loan costs and production and distribution of reports			1,000	1,000	1,500	-	3,500
Total annual costs			2,695	1,955	1,650	-	6300

Travel Please specify details	*Effort on project*		*Financial year 1 April - 31 March*				
	%	months	Year 1 £	Year 2 £	Year 3 £	Year 4 £	Total £
Travel for Glasgow assistant psychologist 6000miles @ 49.3p			986	986	986	-	2,958
Travel for Fife assistant psychologist 9000miles @ 49.3p			1,479	1,479	1,479	-	4,437
Total annual costs			2,465	2,465	2,465		7,395

Exceptional items Please specify details of items applied for	*Effort on project*		*Financial year 1 April - 31 March*				
	%	months	Year 1 £	Year 2 £	Year 3 £	Year 4 £	Total £
Medical statistician Fees	30	5	6000		3000		9000
Annual SPPSS software licences			185	185	185	-	555
Telephone line connection and rental charges and internet monthly fees			700	400	400	-	1500
Total annual costs			6,885	585	3,585	-	11,055

Equipment Description of items and country of manufacture	Date of purchase	Purchase price	VAT £	Total £
2 of Toshiba Satellite 300CDT computers (£1100), with modem (£120) and pre-installed with Windows '95 or '98 and internet explorer (One for Fife, one for Glasgow)		2200	385	2585
2 of MS Office Professional '97 word processing database etc software - one per site (licences only - £180)		360	63	423
SPSS statistical package - base plus additional professional statistics module. For one site only		786	138	924
2 of HP Laserjet 6P printers(£460) - one per site		920	161	1081
4 of Sony tape recorders (£119) with omnidirectional microphone - for recording of therapy sessions to ensure protocol adherence (2 therapists per site)		476	83	559
Total		4,742	830	5,572

Curriculum vitae of applicant(s)
(this form can be copied as necessary)

Surname	*Initials*	*Age*	*Title*
Laidlaw	K.	36	Mr.

Degrees, etc.

1988- 1992 University of Edinburgh*: Psychology MA (hons) Degree Class: First*

1992-1995 University of Edinburgh*: M.Phil in Clinical Psychology*

1996 Chartered Clinical Psychologist

1997 South of Scotland Cognitive Therapy Course; *Certificate*

Posts held (with dates)

1992 -1995 Lothian Healthcare NHS Trust: *Trainee Clinical Psychologist*

1995 -1998 Fife Healthcare NHS Trust: *Grade A Chartered Clinical Psychologist*

1998 -Present Fife Healthcare NHS Trust: *0.6 WTE Grade A Chartered Clinical Psychologist*

1998 -Present University of Edinburgh, *Department of Pyschiatry: 0.4 WTE Lecturer in Clinical Psychology*

Relevant recent publications (with title and reference)

Laidlaw, K. Davidson, K, & Arbuthnott, C. *(in press*) GP referrals to clinical psychology and treatment for depression. Newsletter of The Psychologists Special Interest Group in the Elderly (PSIGE), 60:

Laidlaw, K. (1998) Memory clinics: A review. Generations Review 8:

Laidlaw, K. & Bailey, S. (1997) Psychology out-patient treatment satisfaction and investigation into premature therapeutic termination. British Psychological Society Annual Conference, Edinburgh 3-6 April 1997

Laidlaw, K. (1997) Psychological approaches to the management of depression in older people. Newsletter of The Psychologists Special Interest Group in the Elderly (PSIGE), 59: 9-13

Laidlaw, K. (1996) The personal nature of depression. British Psychological Society Annual Conference, Brighton, 11-14 April 1996

Curriculum vitae of applicant(s)/proposed staff (if known)
(this form can be copied as necessary)

Surname	*Initials*	*Age*	*Title*
Davidson (previously Eunson)	K.M.	43	Dr

Degrees, etc.

M.A. (Hons) Psychology, University of Edinburgh.

M.Phil. in Clinical Psychology, University of Edinburgh

Ph.D. University of Edinburgh

Chartered Clinical Psychologist

AFBPsS

Posts held (with dates)

1994 to present Consultant Clinical Psychologist, GG Community and Mental Health Services (NHS) Trust and Research Tutor, Doctorate in Clinical Psychology,Department of Psychological Medicine, University of Glasgow.

1992 to 1994	Wellcome Trust Clinical Research Fellow (Consultant Clinical Psychologist)
1989-1992	Principal Clinical Psychologist., Royal Edinburgh Hospital.
1985-1989	Senior Clinical Psychologist, Royal Edinburgh Hospital.
1981-1985	Basic Grade Clinical Psychologist, Royal Edinburgh Hospital
1979-1981	Probationer Clinical Psychologist, Lothian Health Board

Relevant recent publications (with title and reference)

Evans K., Tyrer P., Catalan J., Schmidt U., Davidson K., Dent J., Thornton S., Barber J., Thompson S. (In press) Manual-assisted cognitive-behaviour therapy in the treatment of deliberate self-harm: a randomised controlled trial. **Psychological Medicine.**

MacLeod A K., Tata P., Evans K., Tyrer P., Catalan P., Schmidt U., Davidson K., Thornton S., Barber J., Thompson S. (In press) Recovery of positive future thinking within a high-risk parasuicidal group: Results from a pilot randomised controlled trial. **British Journal of Clinical Psychology**

Davidson K.M. and Tyrer P. (1996) Cognitive therapy for antisocial and borderline personality disorders: single case series. **British Journal of Clinical Psychology**, 35, 413-429.

Blackburn I.M. and Davidson K.M. (1990) **Cognitive therapy for depression and anxiety: a practitioner's guide**. Blackwell Scientific Publications Ltd., Oxford. Second revised edition, 1995. Published in Chinese (Yang-Chih book Co.Ltd, Taipei) and in Malay in 1996

Blackburn I.M., Eunson K.M. & Bishop S. (1986) A two year naturalistic follow-up of depressed patients treated with cognitive therapy, pharmacotherapy, and a combination of both. **Journal of Affective Disorders**, 10, 67-75.

Curriculum vitae of applicant(s)/proposed staff (if known)
(this form can be copied as necessary)

Surname	*Initials*	*Age*	*Title*
Toner	H.L.	47	Mr.

Degrees, etc.

M.A.(Hons) in Psychology, St. Andrews University, 1975

Diploma in Counselling, University of Aston in Birmingham, 1976

M. Sc. in Clinical Psychology, University of Melbourne Australia, 1981/2

Chartered Clinical Psychologist

Posts held (with dates)

1976	Part-time University Counsellor and Counselling Trainer, University of Aston
1977-81	Tutor and subsequently Senior Tutor, University of Melbourne Psychology Department. (Mostly part-time)
1981 - 83	Basic Grade Clinical Psychologist Adult and Care of Elderly, Stratheden Hospital, Cupar, Fife.
1983-87	Senior Clinical Psychologist (Elderly Services) Stratheden Hospital, Fife
1987-92	Principal Clinical Psychologist Adult Psychology Dept., West Fife District General Hospital.
1993-95	Head of Over 65s Section of Psychology Dept., Stratheden Hospital
1995-6	Head of Adult Clinical Psychology dept., Stratheden Hospital
1996 - present	Area Head of Fife Clinical Psychology Services

Relevant recent publications (with title and reference)

- McWalter G., Toner H.L, McWalter A., Eastwood J., Marshall M. and Turvey A (1998) A community needs assessment: The care needs assessment pack for dementia (CarenapD) - its development, reliability & validity. *International Journal of Geriatric Psychiatry.* **13 (1):** 16-22
- McWalter G., Toner H.L., Keith D., and McWalter A. (1997) The inter-rater reliability of the Revised Elderly Persons Disability Scale. Report to Scottish Office Chief Scientist of the findings of a CSO Mini Grant funded project.
- McWalter G., Toner H.L, Corser A., Eastwood J., Marshall M. and Turvey A (1996) *Manual of the CarenapD* Dementia Service Development Centre. University of Stirling.
- McWalter G. and Toner H.L. (1996) *CarenapD Application User Manual* Dementia Services Development Centre. University of Stirling.
- Toner H.L. Keith D., Claypool M., Jones I., McDonald S., and Keegan O. (1996) Evaluation of Community Care Alternatives to hospital care of Elderly People. CHSR. Fife.
- Toner H.L., Keith D., Corser A., and Turvey A. (1995) Assessing Continuing Care Needs; Findings from the Fife Healthcare assessment for placement project. *Health Bulletin.*54(2) 152-157.
- McWalter G., Toner H.L., Eastwood J., Corser A. & Turvey A. (1994) Needs and needs assessment: Their components and definitions with reference to dementia. *Journal of Health and Social Care.* 2(4) 213-219.

Appendix 4

Report on previous CSO grant(s)

For each and every CSO grant which you or any of your co-applicants have held as principal applicant and which has begun or terminated over the past five academic years, please give the information requested below (this form should be copied for each grant).

Project title		
Development of a Multidisciplinary Needs Assessment Package for Dementia Sufferers and their Carers		
Project number (if known) K/OPR/2/2/C971		
Start date *October 1991*	*Finish date* *July 1993*	*Date reported* *1993*
Grantholders Toner H.L, Corser A., Eastwood J., Marshall M. and Turvey A		
Current perception of significance		
The main significance of this project was in laying the groundwork for the subsequent project (see next page). It established the theoretical underpinnings of needs assessment, and has contributed to operationalising the notions of needs assessment. It developed the initial version of the CarenapD, which was further developed in the second project and then published (see over).		
Scientific papers directly resulting from this grant		
McWalter G., Toner H.L., Eastwood J., Corser A. & Turvey A. (1994) Needs and needs assessment: Their components and definitions with reference to dementia. *Journal of Health and Social Care*. 2(4) 213-219. McWalter G., Toner H.L., Eastwood J., Corser A. & Turvey A. (1993) The role of needs assessment in planning services. *Newletter of the Psychologists Special Interest Group in the Elderly* (PSIGE) 47. Toner H.L and McWalter G. (1996) The development of a Multidisciplinary Needs Assessment Package for Dementia Sufferers and their Carers. In *Needs Assessment for Dementia Care*. Dementia Service Development Centre. University of Stirling.		

Report on previous CSO grant(s)

For each and every CSO grant which you or any of your co-applicants have held as principal applicant and which has begun or terminated over the past five academic years, please give the information requested below (this form should be copied for each grant).

Project title		
Further Development and Evaluation of a Dementia Needs Assessment Package		
Project number (if known) K/OPR/2/2/D101		
Start date July 1993	*Finish date* October 1995	*Date reported* Feb/ March 1996
Grantholders Toner H.L, Corser A., Eastwood J., Marshall M. and Turvey A		
Current perception of significance CarenapD and its associated software package have been adopted in a number of sites in U.K. It is used as the tool on which the Dementia Services Development Centre (DSDC), University of Stirling, base their training workshops on needs assessment. It is in use in a study by Professor Bob Woods, University of Bangor, Wales, and associates in London		
Scientific papers directly resulting from this grant Toner H.L and McWalter G. (1996) The development of a Multidisciplinary Needs Assessment Package for Dementia Sufferers and their Carers. In *Needs Assessment for Dementia Care*. Dementia Service Development Centre. University of Stirling. Toner H.L and McWalter G. (1996) The development of a Multidisciplinary Needs Assessment Package for Dementia Sufferers and their Carers. In *Needs Assessment for Dementia Care*. Dementia Service Development Centre. University of Stirling. McWalter G., Toner H.L, Eastwood J., Corser A., Marshall M. and Turvey A and Howie C. (1996) *User Manual for the Care Needs Assessment Pack for Dementia.* Dementia Service Development Centre. University of Stirling. McWalter G. and Toner H.L. (1996) *CarenapD Application User Manual* Dementia Services Development Centre. University of Stirling.		

THE SCOTTISH OFFICE

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NHS Management Executive
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Telephone 0131-244
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Mr K Laidlaw
Department of Psychiatry
The University of Edinburgh
Kennedy Tower
Royal Edinburgh Hospital
Morningside Park
EDINBURGH
EH10 5HF

Our ref: K/OPR/2/2/D367

11 February 1999

Dear Mr Laidlaw

A randomised controlled trial of cognitive behaviour therapy versus treatment as usual in the treatment of mild to moderate late life depression

I am writing to formally offer support for your project.

Since the committee reached its decision we have come across a review of trials of cognitive therapy, Gloaguen V, Cottraux J, Cucherat M, Blackburn IM. ***A meta-analysis of the effects of cognitive therapy in depressed patients.*** J Affect Disord. 1998 Apr:49;59-72 (copy enclosed). You may wish to take this into account as you finalise the details of your study.

A specification setting out the details of your grant is enclosed and if there is anything which is not clear of if I can be of assistance in any way please do not hesitate to let me know.

Details of the grant conditions are given in the folder/disc **All you need to know about research grants from the Chief Scientist Office** published in January 1998. It is important that you continue to consult this document for the duration of the grant. Any potential changes in the substance of the project ***must*** be discussed with the appropriate research manager.

Areas that require particular attention are as follows:

- **Ethical approval**

It is necessary for this office to receive a copy of ethical approval and this is required ***before*** the project can start or funds released. Note also that when indicated, approval from the trust management is needed. This is in accordance with paragraph 1.10 of the grant folder.

- **Progress and final reports**

Progress and final reports on projects ***must*** be provided. Details are given in the grant folder. (Part 1A-Forms 3&4, Part 2.10 & Part 3)

- **R & D project details proforma**

All projects funded by the Scottish Office Department of Health (SODoH) are registered with the National Research Register. Please complete the enclosed R & D project details proforma and return to me.

- **Intellectual property rights**

The Intellectual Property Rights (IPR) of research grants funded by the SODoH reside with the Secretary of State. Development and exploitation of IPR is encouraged but ***must*** involve discussion with the CSO.

This support is subject to our **Standard Conditions of Grant** (see part 2 of the grant folder) and a copy of these conditions is enclosed together with 2 copies of **Acceptance of Conditions of Grant.** One copy is for you to retain, the other copy should, after being signed by yourself, cograntholders and your Finance Officer be returned to me. On receipt of the signed **Acceptance of Conditions of Grant** ***and*** the ***Start Certificate*** from your Finance Office a proposed payment schedule will be completed and issued to your Finance Officer. This will indicate the amount of grant which will be released each quarter. Final payments on projects will not be made until the final report has been submitted and assessed by the relevant CSO committee.

A **Final Statement of Expenditure** will be required from your Finance Office within 13 weeks of the finish date of the project.

I should be grateful if you could provide me with the CVs for the 2 Research Assistants and 2 Secretaries to be employed on the grant and the date on which they will take up post. For administrative purposes the start date will be the first day of the month in which expenses are incurred. **Projects should start within 6 months of the acceptance of the conditions of grant.**

From time to time the Scottish Office Information Directorate issue a press release to publicise projects funded by the SODoH. As a grantholder you are therefore asked to provide a summary of no more than 200 words describing your project in plain, non-technical terms for use in the event of it being published in the general press.

I have written to your cograntholders enclosing a copy of the specification and relevant enclosures and also to your Finance Officer advising him that you will be in contact.

The CSO wishes you success in your research endeavours.

Yours sincerely

Mrs Lynn A Murphy

DEPARTMENT *of* PSYCHIATRY

The University of Edinburgh
Kennedy Tower
Royal Edinburgh Hospital
Morningside Park
Edinburgh EH10 5HF

Fax 0131 447 6860
Telephone 0131 537 6000

or direct dial 0131 537 6277

e-mail: k.laidlaw@ed.ac.uk

March 9th 1999

MRS LYNN A. MURPHY
THE SCOTTISH OFFICE
DEPARTMENT OF HEALTH
NHS MANAGEMENT EXECUTIVE
ST. ANDREW'S HOUSE
EDINBURGH
EH! 3DG

Dear Mrs Murphy

A RANDOMISED CONTROLLED TRIAL OF COGNITIVE BEHAVIOUR THERAPY VERSUS TREATMENT AS USUAL IN THE TREATMENT OF MILD TO MODERATE LATE LIFE DEPRESSION; Ref K/OPR/2/2/D367

Thank you for your helpful letter dated the 11th February. I am grateful to you for forwarding the review of trials of cognitive therapy which appeared in the *Journal of Affecvtive Disorders* just recently.

I am in the process of seeking ethical approval from Fife and Glasgow and will forward a copy of ethical approval as soon as possible. Likewise I will forward CVs for the two research assistants and two secretaries as soon as this information is available to us.

Please find enclosed the R & D project details proforma. I also enclose a summary of not more than 200 words describing the above noted project. I hope these are to your satisfaction. I have passed on signed

copies of the Acceptance of Conditions of Grant to Lorraine Kellacher, at ERI and she will forward this to you in due course. I hope this meets your requirements

I look forward to working with you in the future.

Yours sincerely

Ken Laidlaw

Principal Investigator

Distribution:

Kate Davison, PI Glasgow Site,

R&D PROJECT DETAILS PROFORMA

LOCAL ID: K/OPR/2/2/D367

1. Principal methodology(s) used in the project. Please tick the appropriate box(es) below.

- ☐ BEFORE-AFTER-TRIAL
- ☐ CASE-CONTROL-STUDY
- ☐ CASE-SERIES
- ☐ COHORT-STUDY
- ☐ COST-BENEFIT-ANALYSIS
- ☐ COST-EFFECTIVENESS-ANALYSIS
- ☐ CROSSOVER-TRIAL
- ☐ DOUBLE-BLIND-METHOD
- ☐ INTERVIEW(S)
- ☐ META-ANALYSIS
- ☐ NON-RANDOMISED-CONTROLLED-TRIAL
- ☐ PROSPECTIVE-STUDY
- ☐ QUESTIONNAIRE(S)
- ☑ RANDOMISED-CONTROLLED-TRIAL
- ☐ RETROSPECTIVE STUDY
- ☐ SENSITIVITY
- ☐ SPECIFICITY
- ☐ SURVEY
- ☐ SYSTEMATIC-REVIEW

Other methodologies:

Sample Groups (Eg Under 60 Years of Age, Non-Hospitalised Invalid Elderly, etc.)

OLDER ADULTS (AGED 60 – 89 years of age) referred on a non-urgent basis to Clinical Psychology & psychiatry services.

Please tick which of the following strategic categories apply to the project:

- ☐ IMPROVED SCREENING AND IMMUNISATION
- ☐ INFLUENCING LIFESTYLE
- ☐ MONITOR OUTCOME BETTER AND IMPROVE CLINICAL QUALITY
- ☑ TARGET SERVICES BETTER TO NEEDS
- ☐ DEVELOPMENT OF PEOPLE CENTRED APPROACH
- ☐ INTRODUCE AND MONITOR QUALITY STANDARDS
- ☐ REDUCE WAITING TIMES
- ☐ IMPROVE PRIMARY HEALTH CARE
- ☐ DEVELOP CARE IN THE COMMUNITY
- ☐ ORGANISATION AND MANAGEMENT
- ☐ ENSURE STAFF DEVELOPMENT
- ☐ ENSURE STAFF EMPOWERMENT
- ☐ ENSURE APPROPRIATE STAFFING
- ☐ IMPROVE PHYSICAL ENVIRONMENT
- ☐ MAINTAIN FINANCIAL CONTROL
- ☐ CREATE A MORE RESPONSIVE NHS
- ☐ TELEMEDICINE/TELEMATICS
- ☐ NOT WITHIN ANY OF THESE CATEGORIES

Project Title:
A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression

Grant Reference Number
K/OPR/2/2/D367

Summary of Project

Depression is the most common psychiatric disorder amongst older adults. Low expectations regarding treatment success and a fear of possible negative side-effects from antidepressant medication, often leads to clinicians prescribing subtherapeutic levels of medication. It is often incorrectly presumed that depression is a natural consequence of the losses associated with the ageing process. Therefore treatments with recognised efficacy, such as cognitive behavioural therapy (CBT), which are widely available to those under the age of 65 are not offered to older adults with depression. Recent evidence however, suggest treatment for depression in older adults produces beneficial effects even in the most disadvantaged older adults receiving homecare. Evidence suggests that gains made with psychological treatments are maintained at prolonged follow up and CBT may have a value in terms of protecting patients from further episodes of depression.

Currently there is a need for a systematic study investigating the clinical effectiveness of this treatment approach. The proposed study is the first UK evaluation of individual CBT for late life depression. The aim is to compare the efficacy of CBT versus treatment as usual (TAU) alone, generally pharmacotherapy, in late life depression both at the end of active treatment and during six month follow-up.

DEPARTMENT *of* PSYCHIATRY

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June 9th 1999

MRS LYNN A. MURPHY
THE SCOTTISH OFFICE
DEPARTMENT OF HEALTH
NHS MANAGEMENT EXECUTIVE
ST. ANDREW'S HOUSE
EDINBURGH
EH! 3DG

Dear Mrs Murphy

A RANDOMISED CONTROLLED TRIAL OF COGNITIVE BEHAVIOUR THERAPY VERSUS TREATMENT AS USUAL IN THE TREATMENT OF MILD TO MODERATE LATE LIFE DEPRESSION; Ref K/OPR/2/2/D367

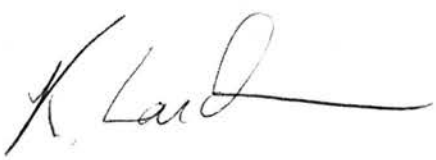
Further to my recent letter to you on the 9th March 1999, and further to our telephone conversation on the 8th June 1999 I am writing to let you know the above noted study (Ref K/OPR/2/2/D367) has received ethical approval from the relevant local research ethics committees. I enclose copies of letters from the relevant ethical committees for your files.

I note that our planned project start date is the 1st September 1999. You may recall from the start of the grant the first three months of the project will be used for producing CBT therapist manuals, training and recruiting Psychology research assistants and developing the project databases as well as pilot-testing the security of randomisation procedure. This means recruitment of participants into the study would start on

December 1st 1999. This date is likely to result in at least a low referral rate to the study and a slow start to recruitment. I would like to ask if it is acceptable to change the formal start of the research grant from the 1st September to the 1st October 1999. This would mean that recruitment into the study starts officially on January 1st 2000. I have discussed this matter with Dr Peter Craig and he has intimated to me that this proposed change is acceptable. I await to hear from you with regard to this matter.

I would like to draw your attention to another matter. The research study has specified a number of measures which are set out in our original grant proposal. With the current measures being used, it is felt that a number of important aspects of depression in older adults are not being addressed. Specifically, it is noted that in the original grant proposal no anxiety or worry measure is being assessed. This is considered an omission as excess worry and anxiety can often be a common aspect to depression in older adults. It is suggested that the inclusion of an additional measure, the 16-item Pennsylvania State Worry Inventory is included in our assessment procedure at the start, end and during the 3 and 6 month follow up phases of the study. It is also noted that there are no measures of cognitive dysfunction in our original grant proposal. It is suggested that the inclusion of additional measures such as the Dysfunctional Attitude scale (DAS), Automatic Thought Questionnaire (ATQ), and the Beck Hopelessness Scale (BHS) are included to remedy this omission. It is proposed that these measures are taken at the start of treatment, at week 8 of treatment, at the end of treatment and at follow-up. I hope this is satisfactory to you. I await to hear from you with regard to this matter.

Yours Sincerely



Ken Laidlaw
Principal Investigator

c.c. Norma Henderson, Edinburgh University Finance Department, Research Grants Section.

DEPARTMENT of PSYCHIATRY

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Dr. Peter Craig
Health Services Research
Chief Scientist Office
St. Andrew's House
EDINBURGH
EH1 3DG

13th July 2000

Dear Dr. Craig

RE: A Randomised Controlled Trial of Cognitive Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression (K/OPR/2/2/D367)

Further to our recent telephone conversation on the 11th July I enclose information on referral and recruitment rate to our research trial. I have been able to update the information I emailed to you on Tuesday as we have received a further entry into our trial.

In total we have received 47 referrals over the whole period of our recruitment (from January 1st to July 12th 2000). Referral to the study really started at week 7 when we received our first referral. In the four months since we started receiving referrals 25 referrals have been received by Fife and 22 have been received in Glasgow. It is interesting that we are beginning to get repeat referrals from a number of practices in both sites. We currently have 19 participants recruited into treatment across the two sites; 13 entered into the trial in Fife and 6 entered into the trial in Glasgow. Our numbers are low but we are continuing to market our study to GPs vigorously.

I will shortly be leaving for my one-year post in Philadelphia with Dr. Aaron T. Beck. A mailing address which can be used for me during my time is:

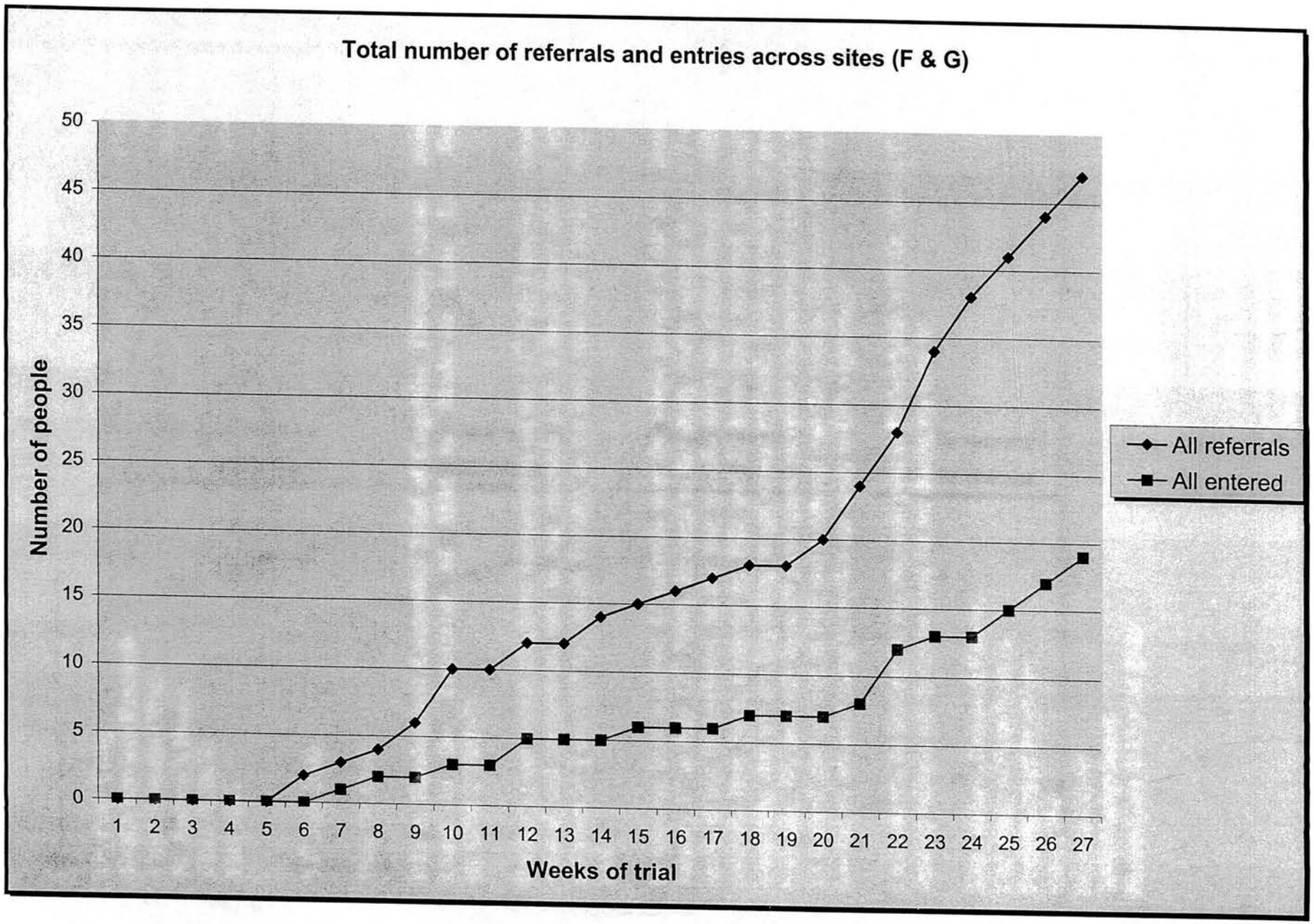
Ken Laidlaw, Research Fellow,
University of Pennslyvania
Department of Psychiatry
Room 754
Science Center
3600 Market Street
Philadelphia, PA19104-2648

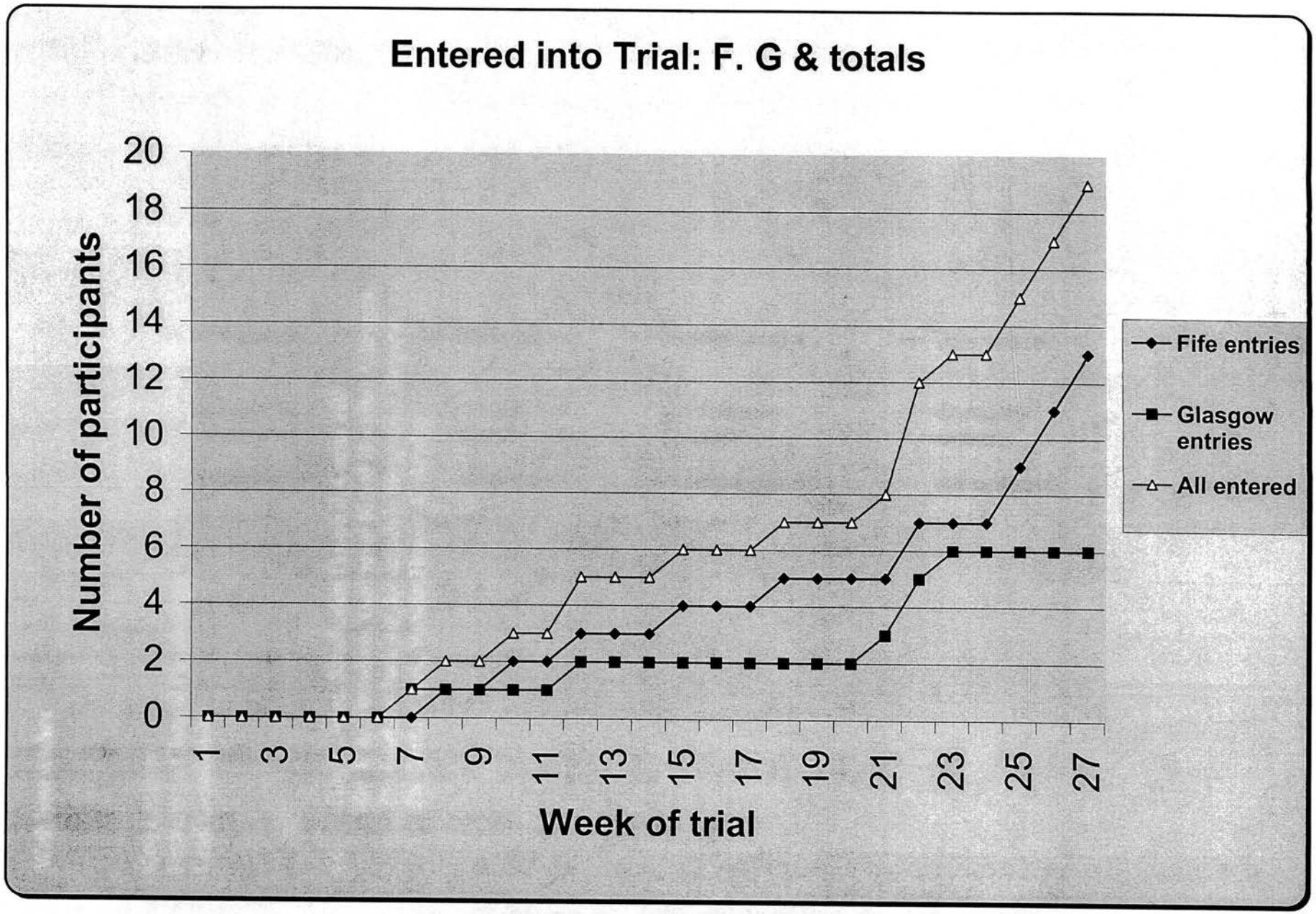
I look forward to your comments on the issue of recruitment into our study. Once again I would like to take this opportunity of thanking you for your support of our endeavours.

With best wishes

Ken Laidlaw
Lecturer in Clinical Psychology
Lead Grantholder

c.c. Hugh Toner, Stratheden Hospital, Cupar Fife
Dr. Kate Davidson, Gartnavel Royal Hospital, Glasgow
Dr. Graham Jackson, Leverndale Hospital, Glasgow
Dr. Stella Clark, Rowan House, Kirkcaldy


Total number of referrals and entries across sites (F & G)
Number of people
50
45
40
35
30
25
20
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
Weeks of trial
All referrals
All entered


Entered into Trial: F. G & totals
Number of participants
0
2
4
6
8
10
12
14
16
18
20
1
3
5
7
9
11
13
15
17
19
21
23
25
27
Week of trial
Fife entries
Glasgow entries
All entered

SCOTTISH EXECUTIVE

Health Department
Chief Scientist Office

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Telephone: 0131-244 2077
Fax: 0131-244 2285
Peter.craig@scotland.gov.uk

Your ref:
Our ref: K/OPR/2/2/D367

Date: 26 April 2000

Dr K Laidlaw
Department of Psychiatry
University of Edinburgh
Kennedy Tower
Royal Edinburgh Hospital
Morningside Park
EDINBURGH
EH10 5HF

Dear Dr Laidlaw

A Randomised Controlled Trial Of Cognitive Therapy Versus Treatment As Usual In The Treatment Of Mild To Moderate Late Life Depression.

Thank you for you Progress Report which we discussed yesterday. The study I mentioned is being conducted by a colleague of yours, Dr Sharpe, so he should be able to provide a copy of the newsletter and also an article on recruitment he and a colleague Dr Jon Stone from the Western General have written for CSO's *Research Matters* newsletter.

With best wishes

Yours sincerely

Diane Brockie

Dr Peter Craig
Research Manager

Dr. Peter Craig
Health Services Research
Chief Scientist Office
St. Andrew's House
Regent Road
EDINBURGH
EH1 3DG

2nd July 2002

Dear Dr. Craig,

RE: A Randomised Controlled Trial of Cognitive Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression. (K/OPR/2/2/D367).

Please find enclosed a copy of the final report on the above noted research study. As you may recall our study was prematurely terminated because of low rates of referrals from GPs in our recruitment areas. As you know we were all disappointed that the study completed early. I think the results presented in the final report provide very interesting reading as cognitive therapy compares very favourably to treatment as usual (generally pharmacotherapy) for late life depression.

I look forward to hearing any comments the committee may have about the study and our findings. May I take this opportunity to state it has been a pleasure to work with you and I am grateful for the help you have given me in my first experience as a principal investigator in research.

Yours Sincerely

Ken Laidlaw
Chartered Clinical Psychologist/ Lecturer in Clinical Psychology
Lead Grantholder

c.c. Hugh Toner, Stratheden Hospital, Cupar, Fife.
Dr. Kate Davidson, Gartnavel Royal Hospital, Glasgow.
Dr. Stella Clark, Rowan House, Kirkcaldy, Fife.
Dr. Graham Jackson, Leverndale Hospital, Glasgow.

Chief Scientist Office - Final Report (Revised)

Project reference: **K/OPR/2/2/D367**	
Start date: **October 1st 1999**	Finish date: **March 31st 2002**

Project title
A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression

Grantholders

Mr. Ken Laidlaw	Dr. Graham Jackson
Dr. Kate Davidson	Dr. Stella Clark
Mr. Hugh Toner	

1. Summary

Efficacy of a structured psychological treatment, cognitive behavioural therapy, is compared with treatment as usual (generally pharmacotherapy) for late life depression.

Depression is the most common psychiatric disorder amongst older adults (Blazer, 2002). Treatment for depression in older people is commonly managed by GPs in primary care (Rothera, et al, 2001). According to published research (Crawford et al, 1998; Orrell et al, 1995; McDonald, 1986), diagnosis does not always translate into care, but when it does, GPs primarily use antidepressants to treat depression in older people. For a variety of reasons, GPs may prescribe subtherapeutic dosages of antidepressants when treating depression in older people (Isometsa *et al,* 1998; Heeren *et al,* 1997; Orrell, *et al*, 1995). Subtherapeutic dosages of antidepressants are used because of fears about the side effect profile of medications in older people (Heeren et al, 1997; Orrell et al, 1995).

Nelson (2001) comments that although there is good evidence for the efficacy of pharmacotherapy as a treatment for late life depression, changes in metabolism in older people increase the risk of toxicity of antidepressants, especially Tricyclic Antidepressants (TCAs), resulting in reduced tolerance for this class of drugs among older adults. Even newer types of antidepressants such as the Selective Serotonin Re-uptake Inhibitors (SSRIs) can cause water retention (consequences include headaches, lethargy and in more severe cases confusion), weight loss and balance problems (Nelson, 2001). Balance problems are potentially very difficult to tolerate in older people, especially for older women, who are at increased risk for hip fractures after falls due to osteoporosis. The efficacious treatment of depression in older people is

important as this can have a negative impact on life expectancy. Depressed in older adults is associated with an increased risk of mortality that is not completely accounted for by poorer physical health (Ames & Allen, 1991) or suicide (Burvill & Hall, 1994). In addition to medical reservations about prescribing, many older people may be unwilling to take medication for depression (Priest et al, 1996). As such there is a need to research effective treatments alternatives to medication and ECT for the treatment of depression in older people (Unutzer et al, 1999; Laidlaw, 2001). Contrary to clinical lore (Leibowitz et al, 1997) older people regard psychotherapy as an attractive treatment option for depression (Landreville, et al 2001). Cognitive therapy is a very effective form of psychotherapy that is particularly appropriate for use with older people as it is problem focussed and skills enhancing (Laidlaw *et al*, in press; Morris & Morris, 1991).

This study is the first UK evaluation of individual CBT for late life depression in a primary care NHS setting. It compared the use of CBT alone with treatment as usual alone (TAU) for older adults with depression. Participants in both treatment conditions improved over the course of treatment and were generally improved at the 6-month follow-up period. Although no significant differences between treatments (CBT vs TAU) emerged at the end of treatment and at 6 months follow-up, psychotherapy (CBT) *by itself* compares favourably with TAU (generally pharmacotherapy). Given the equivalence of outcome between the two active treatments in this study, CBT may be considered a treatment alternative to TAU for mild to moderate late life depression. CBT may be an especially useful treatment alternative when there are contraindications to the use of antidepressants in older people (Lebowitz et al, 1997), or where compliance with medication is very low.

Original aims

This research project investigates whether CBT is an effective treatment alternative to treatment as usual (TAU), generally pharmacotherapy, for late life depression. CBT alone is compared to TAU alone for late life depression at the end of treatment (18 weeks assessment period) and at 6 months follow-up.

2. Methodology

Participants were randomly allocated to one of two treatment conditions; Cognitive behaviour therapy alone or treatment as usual alone. In the TAU condition, there were no constraints upon standard practice. TAU could include any combination of physical treatment for depression, such as prescription of antidepressant medication, physical review, referral to CPN and referral to social services. In the CBT alone condition, participants received up to 20 sessions (spread over an 18 week period) of structured psychological therapy. CBT was administered according to procedures laid out in a treatment manual developed for this study. On average participants received 8.0 (4.7 SD, range 2-17) sessions of CBT. Independent assessors (the research assistants) were 'blind' to treatment condition and each group received equivalent contact from these workers.

Early Termination of the study due to recruitment difficulties

Unfortunately due to lower recruitment than expected, a decision was taken by the CSO to terminate the study. Recruitment of participants proved difficult despite the efforts of all involved in this research study. These efforts included numerous presentations by the investigators to GPs and other referring agencies, provision of information to local mental health teams, written information to GPs, and posters

placed into GP practices. In addition it was emphasised to GPs that the study had a commitment to provide a rapid treatment response (given possible concerns about delayed treatment of depressed patients if referred to a research trial), and to ensure this, the research assistants were supplied with mobile phones to ensure there were no obstacles to rapid respone. Referral was by direct phone call from GP and many of them commented positively on these provisions. Given these extensive efforts, the low recruitment pace was particularly disappointing. Following the termination of the study, we conducted a survey of GPs in Fife and Glasgow who had been informed about the late life depression study.

Results

Overall 114 participants were referred for possible inclusion in the research trial (see appendix 1). In Fife, 62 people were referred and 28 (45 per cent) met inclusion criteria, in Glasgow, 53 people were referred and 16 (30 per cent) met inclusion criteria. The main reasons for non-inclusion in the study were that participants did not meet major depressive disorder criteria or declined the offer to participate in this study. The majority of individuals declined to participate because they were reluctant to be randomly allocated to a treatment condition that could include medication (TAU).

Overall 44 participants were recruited to the study (See table 1 below). Four participants were subsequently removed from our analyses as there was only baseline data on these individuals (3 received TAU alone, and I received CBT alone). Therefore 40 participants were entered for analysis at baseline (22 CBT alone and 18 TAU alone). There were 29 female and 11 male participants. Overall attrition rate

across the study was 17.5 per cent. Six participants withdrew from the study (two in Fife and four in Glasgow), with one additional participant (receiving CBT) being lost to follow-up as they died just prior to the three-month follow-up assessment period. Of the six participants who withdrew from the study, 2 were treated with CBT alone and 4 were treated with TAU alone. Missing data was replaced with last observation carried forward. There were insufficient numbers recruited to this study to allow evaluation of supplementary hypotheses in terms of attrition rates and rates of relapse and recurrence at 6 months follow-up. As can be seen from tables 1 and 2, there were no baseline differences between participants apart from the TAU group reporting slightly elevated levels of anxiety in comparison to the CBT group (PSWI: $t = 2.13$, $df = 38$, $p < .05$, 2-tailed). PSWI scores were also significantly greater for those participants with a previous psychiatric diagnosis ($t = 2.32$, $df = 38$, $p < .05$, 2 tailed).

Sample characteristics at Baseline ($df = 38$)	CBT alone (SD)	TAU alone (SD)	T	P
Mean age	74.3 (8.13)	73.7 (7.9)	**.216**	**NS**
Yrs of Education	10.1 (1.7)	9.9 (1.4)	**.414**	**NS**
Verbal IQ	109.4 (10.6)	108.9 (11.7)	**.134**	**NS**
MMSE: Mini-Mental Status Examination	28.0 (2.2)	28.3 (1.5)	**.450**	**NS**
No. Phys Illnesses	2.2 (1.2)	2.3 (0.8)	**.265**	**NS**
QoL-Phys: Quality of Life Physical subscale,	20.1 (4.1)	18.3 (3.9)	**1.40**	**NS**
QoL-Psych: Psychological subscale	18.0 (2.8)	16.8 (3.8)	**1.12**	**NS**
QoL-Soc.Rel: Social Relationships Subscale	9.5 (2.8)	9.2 (2.1)	**.295**	**NS**
QoL-Environ: Environmental Subscale	29.4 (5.1)	28.8 (4.5)	**.408**	**NS**

Table 1: Sample characteristics

Analysis of outcome using primary measures of outcome, Hypotheses 1 & 2:
Overall, participants in both groups in this study benefited from treatment with reduced scores on primary measures of mood at end of treatment (BDI Beck Depression Inventory: $t = 6.2$, $p < .0001$; GDS Geriatric Depression Scale: $t = 5.5$, $p < .0001$; HAM-D Hamilton Rating Scale for Depression: $t = 6.1$, $p < .0001$; BHS Beck Hopelessness Scale: $t = 2.75$, $p < .01$; all $df = 39$, all 2-tailed) and at 6 months follow-up (BDI: $t = 4.8$, $p < .0001$; GDS: $t = 3.8$, $p < .001$; HAM-D: $t = 5.4$, $p < .0001$; BHS: $t = 2.5$, $p < .05$; PSWI Penn Sate Worry Inventory: $t = 2.54$, $p < .05$, all $df = 33$, all 2-tailed). One-way ANOVAs performed between the two treatment conditions showed that each treatment was equivalent in efficacy at end of treatment (See table 2). At 18 weeks ($df = 1, 39$) there were no significant differences between the treatment groups At 6 months follow-up ($df = 1, 33$) there were no significant differences between the treatment groups (see table 2).

Measure	Treatment group	Mean @ Baseline (SD)	Mean @ 18 Weeks (SD)	Mean @ 6 months (SD)	F	P
BDI	CBT	19.6 (5.3)	10.1 (9.6)	10.8 (9.9)	18 wks .75	NS
	TAU	19.4 (5.4)	12.8 (9.6)	14.1 (10.8)	6mths .88	NS
GDS	CBT	7.6 (2.7)	3.9 (3.7)	4.9 (3.1)	18 wks 1.86	NS
	TAU	8.6 (3.6)	5.4 (3.6)	6.1 (3.7)	6mths 1.02	NS
HAM-D	CBT	11.4 (2.9)	5.7 (4.7)	6.1 (4.9)	18 wks 1.12	NS
	TAU	11.8 (3.0)	7.5 (6.1)	6.5 (5.7)	6mths .07	NS
PSWI	CBT	48.6 (9.6)	47.1 (12.7)	45.1 (12.7)	18 wks .86	NS
	TAU	55.5 (11.0)	50.7 (12.1)	46.3 (11.2)	6mths .08	NS
BHS	CBT	7.7 (4.6)	5.3 (4.3)	4.6 (4.9)	18 wks .21	NS
	TAU	7.1 (3.4)	5.9 (4.1)	6.4 (4.1)	6mths 1.3	NS
Qol Phys	CBT	20.1 (4.1)	21.8 (5.3)	21.0 (5.8)	18 wks 1.01	NS
	TAU	18.3 (3.9)	20.3 (4.2)	21.6 (4.9)	6mths .10	NS
QoL Psy	CBT	18.0 (2.8)	20.3 (3.3)	19.3 (3.5)	18 wks 3.4	NS
	TAU	16.8 (3.8)	18.3 (3.7)	18.3 (3.6))	6mths .66	NS
QoL Soc Rel	CBT	9.4 (2.8)	10.1 (2.6)	10.7 (1.3)	18 wks .20	NS
	TAU	9.2 (2.4)	9.8 (1.2)	10.3 (1.4)	6mths .69	NS
QoL Env	CBT	29.4 (5.1)	30.3 (4.8)	29.4 (2.8)	18 wks 1.19	NS
	TAU	28.8 (4.5)	28.7 (4.0)	28.5 (3.2)	6mths .79	NS

Table 2: Comparison of means between treatments

Repeated-measures ANOVA were performed for both groups on the primary measures of outcome at baseline, at 18 weeks (notional end of treatment), and at 3 month and 6 month follow-up (BDI & BHS were also assessed at 6 & 12 weeks).

There were no significant differences between the treatment groups over time (BDI: F =.94, p = .34; GDS: F = 2.68, p = .11; HAM-D: F = .47, p = .50; BHS: F = .03, p = .88; PSWI: F = 1.2, p = .28; QoL (Phys): F = .16, p = .70; QoL (Psychol): F = 4.41, p = .04; QoL (Soc. Rel.): F = .55, p = .46; QoL (Environment): F = 1.25, p = .27, d*f* = 1, 32 for all). The data are shown graphically in figures 1-5 below.

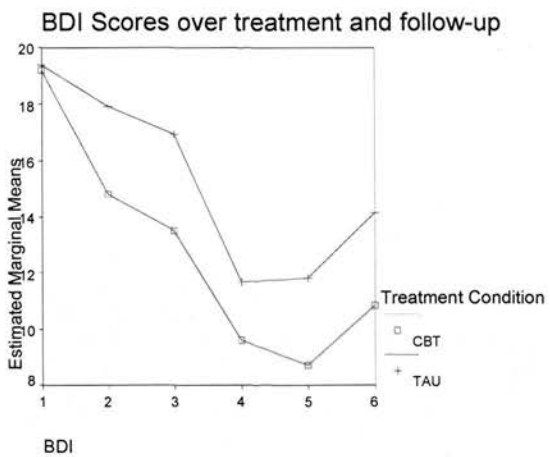

Figure 1: BDI Scores. 4 = 18 wks, 6 = 6mth follow-up

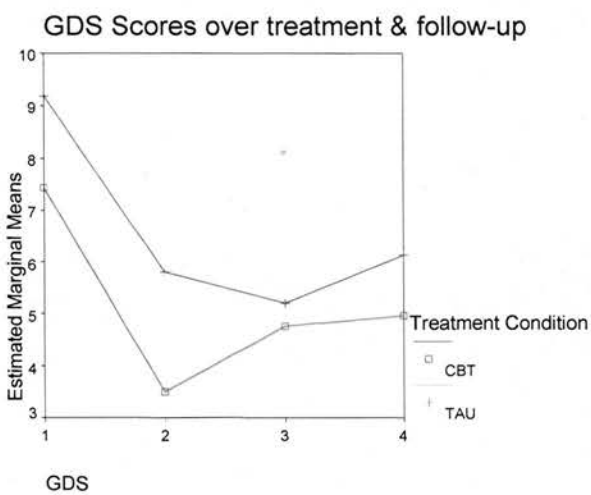

Figure 2: GDS Scores. 2 = 18 wks, 4 = 6mth follow-up

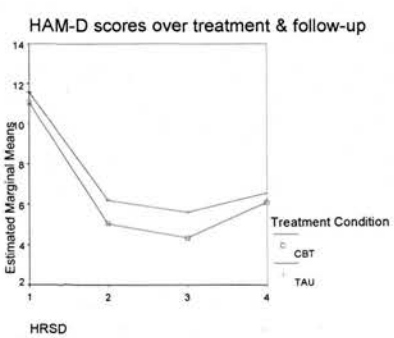

Figure 3: HAM-D Scores.
2 = 18 wks, 4 = 6mth follow-up

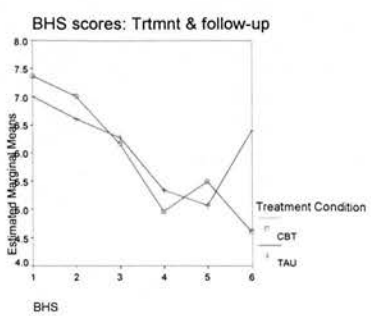

Figure 4: BHS Scores.
4 = 18 wks, 6 = 6mth follow-up

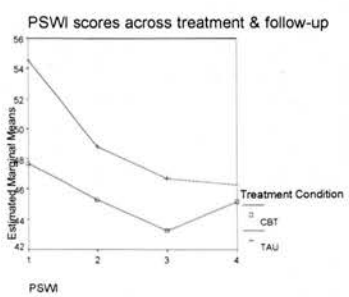

Figure 5: PSWI Scores. 2 = 18 wks, 4 = 6mth follow-up

RDC diagnosis at endpoint.

Research Diagnostic Criteria (RDC) is an accepted method of assessing whether a person meets criteria for diagnosis of major depressive disorder (MDD). Using RDC criteria it is possible to ascertain the number of participants in each group (CBT vs TAU) who remained depressed at 18 weeks (end of treatment) and at 6 months follow-up in comparison to baseline functioning. There were no significant differences between the groups in terms of numbers of participants meeting RDC criteria for depression at end of treatment (Chi Square = .839, p = ns) and at 6 months follow-up (Chi Square = 2.34, p = ns). However, it is of interest to note that using RDC criteria, 30 per cent of the CBT treatment group were still considered depressed at 6 months follow-up, whereas, 53 per cent of the TAU treatment group were still considered depressed at 6 months follow-up. This figure is calculated using the numbers still in contact with the study at the end of follow-up. This figure may inflate response to treatment, therefore, if it is conservatively assumed that those participants who have dropped out of the study at the 6month follow-up period are likely to still meet depression criteria, then 45 per cent of the CBT treatment group were still considered depressed at 6 months follow-up, whereas, 61 per cent of the TAU treatment group were still considered depressed at 6 months follow-up.

The numbers of participants meeting RDC criteria for depression and the numbers of participants not meeting RDC criteria for depression are illustrated graphically in figures 6 & 7 below.

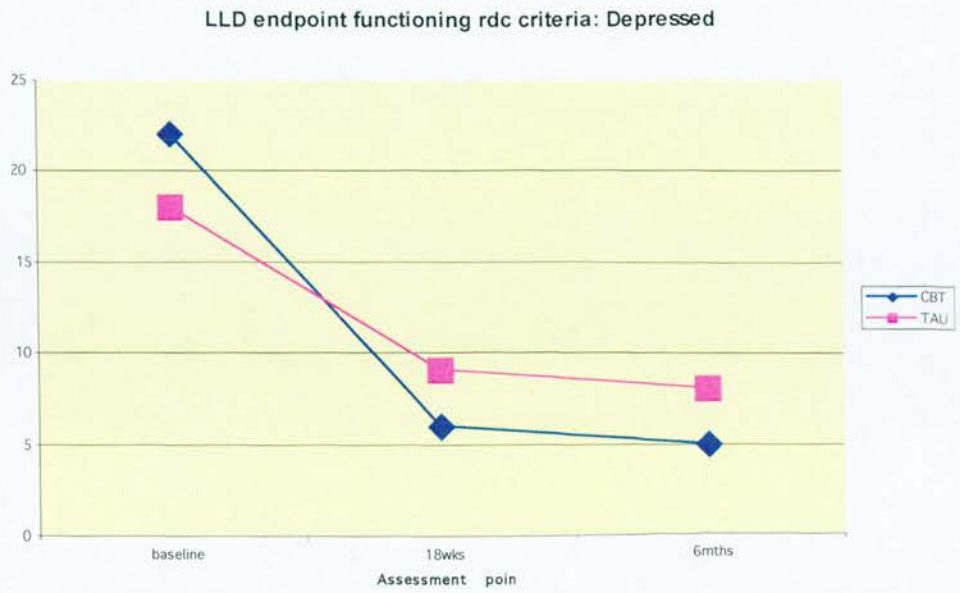

Figure 6: Number of participants in each treatment group considered depression over the course of treatment and at follow-up

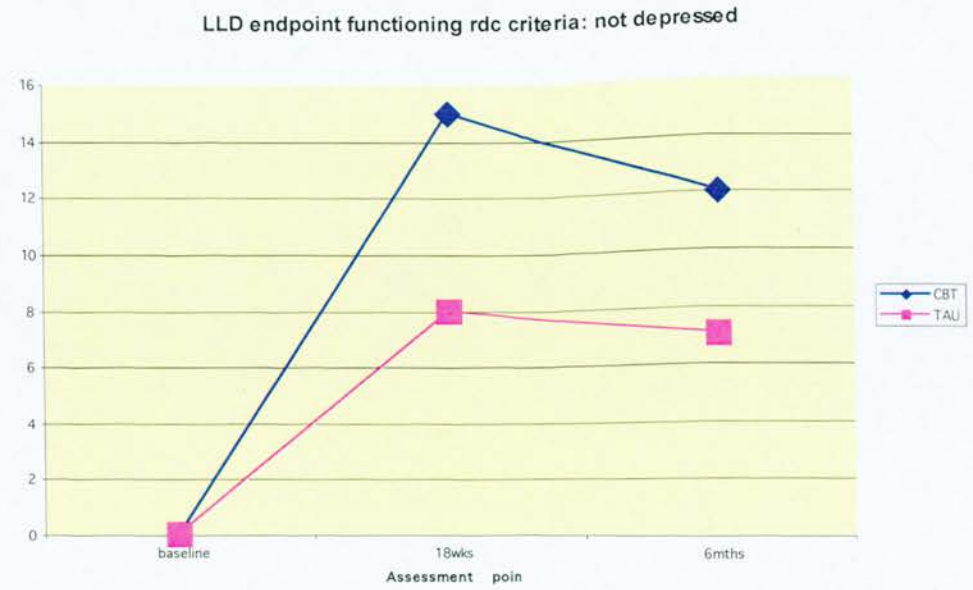

Figure 7: Number of participants in each treatment group considered no longer depressed over the course of treatment and at follow-up

GP Survey Data

Given the low levels of recruitment from GP sources to our study, it was considered prudent to undertake a survey of GP's attitudes to referring to our study and to research in general. 300 survey forms were posted to GP practices in Fife and

Glasgow and 160 questionnaires were returned, with 98 out of 150 returned in Fife and 62 out of 150 returned from Glasgow. Of the overall sample, 61.3 per cent of respondents were male and 38.7 per cent were female. The sample were quite experienced as they reported on average 20.4 years (SD 8.56) since qualification and 54 per cent had some training in general psychiatry. The average age of respondents was 44.3 years (SD 8.86).

Overall it would appear that the various means used to inform GPs of our study met with some success, as 72.3 per cent of respondents stated they were aware of the Late Life Depression study. Of those GPs who were aware of the study, 56.3 per cent wished to refer to it but were unable to find suitable candidates. Despite the high visibility of our study with GP survey respondents, of those respondents who were aware of this study, only 29.6 per cent actually referred to our study. In addition to demographic questions, the survey contained a series of nine statements (see table 3 below). GPs were asked to respond to each statement on a five point visual analogue type scale that was anchored 0 (disagree with statement) and 4 (agree with statement). The survey respondents' median and modal response to survey statements are summarised in table 3. The significance of responses to questions 1-3 is discussed below.

No.	Statement	Median	Mode
1	I am confident in my ability to treat depression in older people?	3	3
2	Depression in older people is often masked by other physical illnesses	3.3	3
3	Depression is more likely in older people due to the challenges of ageing	2.95	3
4	I don't think my over 65 patients would want to take part in a research study	1	1
5	I don't think my over 65 patients would talk to a psychologist (or a therapist) about their depression	1	1
6	I would have been more likely to refer patients to a trial of psychotherapy where I was free to prescribe as I saw appropriately	1.45	2
7	What with the chronic illnesses older people have to deal with, I think depression is the least of their worries.	.65	1
8	Research studies are there for the benefit of researchers	1	1
9	Research studies are just one more burden and I am overworked already	2	2

Table 3: GP response to statements in Survey Questionnaire

Economic Analyses

At baseline, end of treatment and at 6 months follow-up there were no significant differences in any econometric assessment of services (formal and informal) consumed by participants in both treatment groups.

3. Discussion

In this study participants, in both treatment conditions, improved at end of treatment and at 6 months follow-up in comparison to baseline scores on a range of mood measures. Psychotherapy performs well as a treatment for late life depression and is of comparable efficacy to TAU (generally pharmacotherapy). TAU (e.g. pharmacotherapy) was unconstrained and it is therefore probable that treatment continued during the 6 month follow-up phase, *while the CBT group completed*

treatment at 18 weeks, and on average completed treatment within 8 sessions, well before the 18 week time period. Participants in the CBT group maintained gains after treatment had formally ceased. CBT group scores were below caseness on the BDI at 6 months follow-up whereas the TAU group scores were not. The TAU group never achieved non-caseness on the GDS at any assessment period, whereas the CBT group were below caseness at end of treatment and at 6 months follow-up. Given that small numbers in this sample make it unlikely that power is sufficient for statistical significance, results showing the CBT group reporting lower scores than the TAU group on <u>all</u> mood measures provide evidence that psychotherapy for older adults proved at least as effective as TAU alone. The numbers recruited to this study are inadequate to discuss attrition in the treatment groups. However, some discussion can be made with regard to endpoint functioning as assessed by RDC criteria for major depressive disorder. The CBT alone group endpoint functioning was at least comparable to that of the treatment as usual group as there were no statistical differences in the numbers of participants in each treatment condition who were no longer considered depression at 6 month follow-up. As there is equivalence of outcome, the findings suggest that CBT alone can be a treatment alternative to TAU alone.

Recruitment difficulties were experienced in this study. Despite consistent efforts on the part of the researchers to increase referrals, GPs failed to refer adequate numbers. Data from the GP survey suggests that many were aware of the study and many were willing to refer, but were unable to identify suitable candidates. The GP survey responses appears to rule out some of the potential reasons for low referral rates, as GPs did not think that older people would be unwilling to participate in therapy or in

research and neither were our GPs survey respondents put off referring to the study because they were not free to prescribe medication. While it remains uncertain what were the precise reasons for low referral rate, there are some possible pointers in the responses by GPs to statements 1-3 in table 3. These responses may be taken to suggest that as depression is seen by GPs as something they can confidently treat themselves, they may feel less compelled to refer on to other agencies. Secondly a number of GPs considered depression in older people to be masked by physical illness and hence may have considered these sorts of cases as less suitable for psychological management, or perhaps are indicating that in these groups depression may indeed be more difficult to diagnose. Finally GPs appear to endorse the notion that depression is more likely to be due to the challenges of ageing. Unitzer et al (1999) has noted that the 'fallacy of good reasons' which see depression as somehow normal in response to challenges of ageing, results in therapeutic nihilism. GPs may therefore have considered depression in some older people as a normal response to normal circumstances. In such instances, it is unlikely GPs would have considered such individuals to be appropriate for referral.

4. Conclusions

Despite the limitations of the small sample size, the study showed that participants in both treatment conditions significantly improved over the course of treatment and were still improved on primary measures of mood at 6-months follow-up. Both treatments in this randomised controlled trial resulted in improvement in functioning in depressed older adults living in the community. With equivalence of outcome, at both the end of treatment and at 6 months follow-up, psychological therapy (CBT) on its own can be considered to be as effective as TAU (generally pharmacotherapy) for the treatment of mild to moderate late life depression. CBT alone may be a useful treatment alternative to antidepressant medication when older people are unable to tolerate this treatment due to side effects or where adherence to treatment regime is proving difficult to maintain, or where an older person requests psychological treatment instead of physical treatment.

5. Importance to NHS

For the first time in a primary care setting, a psychological treatment alone for older people with depression has been shown to have equivalent functioning to usual care as delivered by general practitioners. This is important as many older people cannot tolerate medication because of their side effects. The equivalence of outcome does not suggest that one treatment is better than the other, but the importance to the NHS is that a psychological treatment on its own can be of benefit to older people who are diagnosed with mild to moderate major depressive disorder. As older people with depression are more likely to consult their GPs and since many GPs appear concerned about prescribing full dose regimes of antidepressants to older people (Crawford et al, 1998; Isometsa et al, 1998; Orrell et al, 1995) then an alternative to antidepressants

needs to be evaluated so as to reduce the burden of care on GPs and those who are likely to come into contact with depressed older people in primary care.

The results of this study are important to GPs and CPNs who may have been unaware that older people can benefit from psychotherapy as a treatment alternative to medication for depression. This is important as health care professionals working in NHS settings will increasingly come into contact with older people and will need to become much more aware of treatment issues and efficacy data for the treatment of late life depression.

The importance of this data to older people themselves is in demonstrating that they have a choice of treatments for depression. Given increasing awareness that older people are often reluctant to be prescribed psychotropic medication or medication may be contraindicated because of other health problems this is an important treatment alternative.

The findings of this study are important to policy makers since Scotland along with the rest of Europe (Kinsella & Velkoff, 2001), is experiencing a relatively large increase in the numbers of older people (especially the oldest old) living in Scotland (Woods & Bain, 2001). Increasing longevity is a major societal achievement, and a challenge (WHO, 2002), and policy makers will wish to invest in treatments that ensure the relatively large numbers of older people in Scotland live healthier not just longer (EGHOP, 2002).

6. Future research

An obvious point for future research is to further investigate CBT as a treatment for late life depression. Further research might usefully focus on investigating the potential of CBT as a treatment for depression in older people with a comorbid physical illness. Examples of areas of future research for CBT are in depression following stroke, following Parkinson's disease and depression amongst nursing home residents. Rates of depression are high in these conditions but treatments are relatively under-researched in terms of efficacy.

Another area of future research potential is late life suicide (Conaghan & Davidson, 2002). Suicide rates for persons aged 65 years and older are higher than for any other age group in the UK (Kinsella & Velkoff, 2001). Recent psychological autopsy studies suggest that older adults who complete suicide are likely to have visited their GP one month prior to their suicide act and exhibit high levels of depression (Caine et al, 1996). While depression does not necessarily result in suicide, amongst older people who make suicide attempts, depression is the most frequent diagnosis (Blank *et al,* 2001; WHO, 2001).

7. Dissemination

The findings of this study will be made available to the scientific community by presentation of a series of talks at national and international conferences (BABCP, GSA, AAGP) and a paper is in preparation for submission to a peer reviewed journal. The Chairs of local LHCCs are currently being contacted to promote dissemination of these research findings at the level of primary care.

8. Research workers

Psychology Research Assistants:

Year 1:	Fife – Jim Law (September 1999-September 2000)
	Glasgow – Mary Howley (September 1999-September 2000)
Years 2-3	Fife – Gillian Bowie (October 2000 – March 2002)
	Glasgow – Hazel Connery (October 2000 – September 2001).

Administrative Assistance:

Fife:	Mrs C. Mitchell (October 1999 – March 2002)
Glasgow:	Mrs A. Asthana (April 2000 – May 2001)

9. Financial statement

As the research trial discontinued recruitment earlier than planned (Study completed 31st March, 2002 but was originally planned to complete 30th September 2002), there is a surplus of funds. In addition to terminating recruitment earlier than originally planned, costs were saved by non-replacement of staff. In Glasgow, the administrative assistant left in May 2001 and was not replaced as the Fife administrator took on additional duties. In Glasgow the research assistant was not replaced when she left to take up a training position in September 2001, and her duties were taken over by the Fife research assistant who was given some additional compensation for this (increase in spine point and additional one-half session a week from October 2001 to March 2002). The accounts are listed in table 4 below for each financial year of the project.

	Allocated	Expenditure Oct '99 – Mar '00	Expenditure Apr '00 –Mar '01	Expenditure Apr '01 – Mar '02	Total expenditure	Residual
Staff Costs	**95,904.00**	7153.43	30,735.65	31720.19	**69609.27**	26294.73
Equipment Costs	**5572.00**	3182.45	0.00	0.00	**3182.45**	2389.55
Consum-mables	**6300.00**	1669.75	1035.92	2486.56	**5192.23**	1107.77
Travel	**7200.00**	426.80	3711.20	2725.43	**6864.31**	335.69
Other	**2055.00**	0.00	1691.35	0.00	**1691.35**	363.65
Total (ex indirect)	**117,031.00**	12,432.45	37,174.98	36,932.18	**86,539.61**	30,492.62
Indirect costs	**36,872.00**	2,861.35	12,294.28	11047.37	**26203.81**	10668.19
Totals (incl. Indirect costs)	**153903.00**	15,293.80	49,469.26	11047.37	**112,743.42**	41159.58

Table 4: Financial costs associated with grant by year (Oct. 1, 1999 – Mar. 31, 2002)

10. Executive Summary

This study compared Cognitive Behaviour Therapy (CBT) alone versus treatment as usual alone (TAU), generally pharmacotherapy. Depression is the most common psychiatric disorder amongst older adults and the consensus is that depression in later life is likely to be associated with increasing relapse and recurrence and high suicide risk.

This study is the first UK evaluation of individual CBT for late life depression, and therefore addresses a need for a systematic study investigating the clinical effectiveness of structured psychotherapy (CBT) in an NHS primary care setting. The results demonstrated equivalent clinical outcome for participants in both treatment conditions over the course of treatment, and at 6 months follow-up. CBT alone for the treatment of mild to moderate late life depression may be a useful treatment alternative to antidepressant medication when older people are unable to tolerate this treatment due to side effects or where adherence to treatment regime is proving difficult to maintain, or where an older person requests psychological treatment instead of physical treatment.

APPENDIX SIX:

SADS-L BOOKLETS

LATE LIFE DEPRESSION PROJECT

SCHEDULE FOR AFFECTIVE DISORDERS AND SCHIZOPHRENA
(SADS)
&
LONGITUDINAL INTERVAL FOLLOW-UP EVALUATION
(LIFE-II)

SCORING SHEETS

NAME	
DOB	
ADDRESS	
TEL	
INTERVIEWER	

SADS Questions to ask
Part One

1. I would like to hear about any problems / difficulties you are having in your life just now?

2. How different is this trouble been from the way you were before or usually are?

3. How long was it from when you first noticed that something was wrong until you went to see your GP?

4. Are you feeling better now or is it at its worse?

5. If better now, how long has it been since you were really depressed?

6. When did you last feel like your usual self for a couple of months?

Duration of Episode

7. Did anything happen before you started feeling this way / got sick?

8. Was there any big change in your life.....like your health....money.....job...or your family?

9. Were you taking any drugs or medication just before you had this trouble?

10. Were you physically ill before you had this trouble?

11. Did anyone close to you die?

12. What is your opinion as to whether (events) had anything to do with you becoming sick / depressed?

13. Did you think it had nothing to do with what was going on in your life or do you think it was possibly, most likely or almost certainly related?

Treatment

14. Did you see any professional person for these problems?

15. What kinds of treatment did you receive ECT, Lithium, antidepressants, tranquilizers, psychotherapy/counselling?

16. During this time when would you say it was at its worse?

For the rest of the interview I will be asking you questions about different kinds of problems that some people have. If you have had any of them during this period of difficulty I would like to know how bad they were when they were at their worst.

Mood

17. How have you been feeling?. Can you describe your mood?
18. Have you been depressed(sad, blue, down or empty as if you didn't care?, Have you cried or been tearful? How often? Does it come and go? How long does it last?
19. How bad is the feeling? Can you stand it?
20. What about during the past week?

21. Is this feeling of mood different from the usual feeling you would have after watching a sad film or if someone close to you died?
22. How is the feeling different?
23. When you feel this way, do you always know that you are depressed or do you sometimes just feel bad and do not know why?

Worrying

24. Have you been worrying a lot?
25. How much do you worry?
26. What kinds of things have you been worrying about?
27. How much of the time do you spend worrying?
28. Are you able to get your mind of it?

What about the past week?

Guilt

29. Do you blame yourself for anything that you have done?
30. What about feeling guilty?
31. Do you feel you have done anything wrong?
32. Do you deserve punishment?
33. Do you feel you have brought this on yourself?

What about the past week?

Neg evaluation

34. How do you feel about yourself?
35. Are you down on yourself?
36. What is your opinion of yourself compared to other people, i.e worthless, failure?
37. How often do you feel this way?

What about the past week?

Pessimism, hopelessness

38. Have you felt discouraged, pessimistic or hopeless?

39. What kind of future do you see for yourself?
40. Do you think things will work out?
41. Can you see things getting nay better?
What about during the past week?

Suicidal, thoughts of death

42. When a person gets upset, depressed, he may think about dying or even killing themselves, Have you?
43. Have you thought about how you would do it?
44. Have you told anyone about suicidal thoughts?
45. Have you actually done anything?
What about in the past week?

Number of suicide gestures/attempts

46. What did you actually do?
47. How were you found?
48. Did you really want to die?
49. How close were you to really killing yourself?

Insomnia

50. Have you trouble sleeping?
51. What about falling asleep?
Or waking up in the middle of the night?
Or up early in the morning before you want to get up?
52. How bad does it get?
What about during the past week?

53. Are you sleeping more than usual?
54. Do you go back to sleep or reset the alarm, How much more? How often?
55. What about taking naps during the day?

Energy (physical)

56. Have you had less energy than usual to do things, or have you been getting more tired more easily?
(not talking about interest in things but your physical energy to do things)

Appetite, compared to usual

57. What about appetite for food compared to the way it usually is?
58. Do you have to force yourself to eat?
59. Are you eating less than usual?
60. How Much?
61. Have you lost any weight?

62. Have you noticed an increase in your appetite?

63. How much have you been eating?
64. how much weight have you gained?

Concern Health

65. Do you worry much about your health or how your body is working?
66. How has your physical condition been?
67. Any aches/pains?

What about during the past week?

Indecisiveness

68. Have you had any difficulty making everyday decisions?
69. Has it taken you longer to make decisions than when you were feeling good?, like what to wear, what to cook, where to go, what to buy?
70. Are their things that you cant get done because you cant decide what to do?

Concentration

71. Have you trouble concentrating?
72. Is your thinking slowed?
73. When do you have trouble?
74. What difficulties does it cause?
75. Is that because you cant concentrate or just that you are not interested?

Loss of Interest / pleasure from activities

76. Do you find that you have lost interest in or get less pleasure from the things that you used to enjoy, like your friends, family, hobbies, sex, watching TV, eating?
77. What things have you lost interest in?
78. Which things do you still enjoy?
79. Are there things that you still enjoy as much as usual?

What about the past week?

Social Withdrawal

80. Have you had less to do with people than usual?
81. What about less active in church, bowling, etc?
82. Have you preferred to be by yourself?
83. Have you turned down or avoided any situations where you knew you would be with people?
84. Have you stopped calling your friends?

Depersonalization

85. Have you felt as if you were outside of your own body, or as if part does not belong to you, or that you are physically cut off from people, or floating or like you were in a dream?

Anger

86. How annoyed angry or resentful have you felt?
87. How much of the time did you feel like this?

What about the past week?

88. How did you show your anger, annoyance, irritability?
89. Did you get into heated arguments, did you lose your temper, throw or break things, what about hitting people?

What about the past week?

Agitation

90. When you were depressed were there times when you were unable to sit still or did you always have to be moving or pacing up and down?
91. Did you wring your hands?

What about the past week?

Psychomotor retardation

92. When you did things were you slowed down because you couldn't move as quickly as usual?
93. Was your speech slowed?
94. Did you feel like you were moving in slow motion?
95. Did you find it hard to start speaking?
96. How long did it last?
97. Did you speak a lot less than usual?

What about the past week?

98. During that week when you were feeling your worst, did that feeling ever go away when you got your mind other things or when something pleasant happened? – like hearing good news or talking to a friend or did you feel bad no matter what was happening? If someone tried to cheer you up could they?
99. Was there any part of the day in which you usually felt better or worse, or didn't it make a difference.

LATE LIFE DEPRESSION PROJECT

*SCHEDULE FOR AFFECTIVE DISORDERS AND SCHIZOPHRENA SADS**

ANSWER BOOKLET

NAME	
DOB	
ADDRESS	
TEL	
DATE SEEN	
INTERVIEWER	

*Developed by Robert L. Spritzer, MD, and Jean Endicott, Ph.D. with the assistance of the other participants in the NIMH Clinical Research Branch Collaborative Program on the Psychobiology of Depression

PART I

Duration		**0**	**No information**
		1	**< 2 days**
		2	**2 days to 1 week**
		3	**1 week to 2 weeks**
		4	**2 weeks to 1 month**
		5	**1 month to 2 months**
		6	**2 months to 3 months**
		7	**3 months to 1 year**
		8	**1 year to 2 years**
		9	**2 years or more**
Onset		**0**	**No information**
		1	**< 2 days**
		2	**2 days to 1 week**
		3	**1 week to 2 weeks**
		4	**2 weeks to 1 month**
		5	**1 month to 2 months**
		6	**2 months to 3 months**
		7	**3 months to 1 year**
		8	**1 year to 2 years**
		9	**2 years or more**
Life Event		**N/A**	
		0	**No information**
		1	**No apparent stressor**
		2	**Minimal stressor**
		3	**Mild stressor**
		4	**Moderate stressor**
		5	**Severe stressor**
		6	**Extreme stressor**
Associated Event			
Causality		**0**	**No information**
		1	**No relationship**
		2	**Possibly related**
		3	**Most likely related**
		4	**Almost certainly related**
Treatment	***Outpatient***	**0**	**No information**
		1	**No contact**
		2	**<2 weeks of treatment**
		3	**>2 weeks of treatment**
	Inpatient	**0**	**No information**
		1	**No**
		2	**Yes (number of hospitalisations?)**

Treatment(s) received

ECT
Lithium
Antidepressants
Minor tranquillisers
Major tranquillisers
Other
Psychotherapy or counselling

DYSPHORIC MOOD

Depression

0 **No information**
1 **Not at all**
2 **Slight**
3 **Mild**
4 **Moderate**
5 **Severe**
6 **Extreme**
7 **Very extreme**

Past 2 weeks: 0 1 2 3 4 5 6 7

1. Quality

0 **No information**
1 **No difference**
2 **Minimal difference**
3 **Definitely different**
4 **Very different**
Description _____

2. Reactivity

0 **No information**
1 **Nearly always**
2 **Most of the time**
3 **Usually not**
4 **Practically never**

Worrying

0 **No information**
1 **Not at all**
2 **Slight**
3 **Mild**
4 **Moderate**
5 **Severe**
6 **Extreme**

Past 2 weeks: 0 1 2 3 4 5 6

Worthlessness
Do not include if simply negative Evaluation of self

0 **No information**
1 **Not at all**
2 **Slight**
3 **Mild**
4 **Moderate**
5 **Severe**
6 **Extreme**

Past 2 weeks: 0 1 2 3 4 5 6

Negative Self-concept

0 No information
1 Not at all
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Pessimism

0 No information
1 Not at all discouraged
2 Slightly
3 Mildly
4 Moderately
5 Severely
6 Extremely

Past 2 weeks: 0 1 2 3 4 5 6

Suicide

0 No information
1 Not at all
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme
7 Very extreme

Past 2 weeks: 0 1 2 3 4 5 6 7

Number of gestures in past year: **NI 0 1 2 3 4 5 6 7 8 9+**

Seriousness of intent

0 No information
1 Manipulation (no intent)
2 Minimal
3 Definite
4 Serious
5 Very Serious
6 Extreme

Medical Lethality

0 No information
1 No danger
2 Minimal
3 Mild
4 Moderate
5 Severe
6 Extreme

Panic attacks

0 No information
1 None
2 Questionable
3 Definite (list physical symptoms)

Shortness of breath
Palpitations
Chest pain/discomfort
Choking
Vertigo
Paressthesia
Faintness
Sweating
Trembling
Fear of dying

Number of weeks with at least 1 panic attack:

1 2 3 4 5 6 7 8 9+

Somatic anxiety

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Psychic anxiety

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Phobia

0 No information
1 None
2 Uncomfortable
3 Definitely uncomfortable
4 Very uncomfortable/no consequences
5 Very uncomfortable/consequences
6 Marked avoidance

Past 2 weeks: 0 1 2 3 4 5 6

Type of phobia _____

Obsessions or compulsions

0 No information
1 None
2 Occasional
3 Definite but infrequent
4 Frequent
5 Very frequent
6 Dominating

Past 2 weeks: 0 1 2 3 4 5 6

Insomnia

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Type of insomnia _____

Past 2 weeks: 0 1 2 3 4 5 6

Hypersomnia

0 No information
1 None
2 Occasionally
3 Frequently (1 hour longer)
4 Frequently (2 hours longer)
5 Frequently (3 hours longer)
6 Frequently (4 hours longer)

Fatigue

0 No information
1 None
2 Possibly
3 Definitely at times
4 Often
5 Almost always
6 Constantly

Past 2 weeks: 0 1 2 3 4 5 6

Poor appetite

0 No information
1 None
2 Slightly
3 Mild
4 Moderate
5 No appetite – forces self to eat
6 No appetite – fed by others

Past 2 weeks: 0 1 2 3 4 5 6

Weight loss

0 No information
1 None
2 Doubtful or up to 5lbs
3 5 – 10lbs
4 11 – 15lbs
5 15 – 25lbs
6 Over 25lbs

Increased appetite

0 No information
1 None
2 Slightly
3 Mild
4 Moderate
5 Hungry all the time but restrains self
6 Hungry all the time, no restraint

Weight gain

0 No information
1 None
2 Doubtful or up to 5lbs
3 5 – 10lbs
4 11 – 15lbs
5 15 – 25lbs
6 Over 25 lbs

Hypochodriasis

0 No information
1 None
2 Occasional
3 More frequent
4 Preoccupied at times
5 Often absorbed
6 Almost always absorbed

Past 2 weeks: 0 1 2 3 4 5 6

Indecisiveness

0 No information
1 None
2 Slight
3 Subjective feeling of indecisiveness
4 Unable to make some decisions
5 Severe
6 Paralysing indecisiveness

Concentration

0 No information
1 Not at all (normal)
2 Slightly poorer
3 Definitely poorer
4 Interferes with functioning sometimes
5 Interferes with functioning often
6 Inability to concentrate at all

Anhedonia

0 No information
1 No change in interest or pleasure
2 Slight change
3 Several activities less pleasurable
4 Most activities less pleasurable
5 Almost all activities less pleasurable
6 All activities less pleasurable

Past 2 weeks: 0 1 2 3 4 5 6

Social withdrawal

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Depersonalisation/derealisation

0 No information
1 None
2 Slight
3 Occasional
4 Several or 1 prolonged experience
5 Marked
6 Frequent or very prolonged

Subjective feelings of irritability

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Overt expression of irritability

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Agitation

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Manifestations included:

Unable to sit still
Pacing
Handwringing
Pulling or rubbing hair, skin etc.
Outbursts of shouting
Talks on and on (Garrulous)

Retardation

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Manifestations Included:

Slowed speech
Pauses
Low or monotonous speech
Mute
Slowed body movements

Past 2 weeks: 0 1 2 3 4 5 6

CHARACTERISTICS OF DYSPHORIC AFFECTIVE DISTURBANCE

0 Not applicable
1 Depressed mood
2 Emotional turmoil
3 Anxious mood
4 Other

If 0, 2, 3, or 4 skip to Screening items for Manic Syndrome

Reactivity

0 No information
1 Very responsive
2 Usually responsive
3 Often responsive
4 Somewhat responsive
5 Rarely feels better
6 Unresponsive

Diurnal mood variation

Worse in the morning:
0 No information
1 Not worse
2 Minimally worse
3 Mildly worse
4 Considerably worse

Worse in the evening:

0 No information
1 Not worse
2 Minimally worse
3 Mildly worse
4 Considerably worse

SCREENING ITEMS FOR MANIA

Elevated or expansive mood

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Less need for sleep

0 No information
1 No change
2 1 hour less
3 2 hours less
4 3 hours less
5 4 hours less
6 >4 hour less

Past 2 weeks: 0 1 2 3 4 5 6

Unusually energetic

0 No information
1 No difference
2 Slightly more energetic
3 Less fatigued than usual
4 More active than usual
5 Much more active than usual
6 Unusually active

Past 2 weeks: 0 1 2 3 4 5 6

Increased activities

0 No information
1 No change
2 Slightly more
3 Mild
4 Moderate
5 Marked
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Grandiosity

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

☐ **If all of the previous 5 screening items were rated 1 or 2 tick the box and skip to the section on Alcohol Abuse. If any of the items are rated more than 2 complete this section.**

Overt expression of irritability

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Hyperactivity

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Accelerated speech

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Marked
6 Extreme

Subjective thought acceleration

0 No information
1 None
2 Suspected
3 Definite

Other disturbed behaviour

Intrusive, provocative, demanding
Public disturbance
Financial indiscretion
Poor judgement
Antisocial behaviour
Sexual excesses
Drunkenness
Bizarre behaviour

Poor judgement

0	No information
1	None
2	Slight
3	Mild
4	Moderate
5	Severe
6	Extreme

Duration of behaviour

0	No information
1	Less than 3 days
2	Less than 1 week
3	1 to less than 2 weeks
4	2 weeks or more

ALCOHOL ABUSE

0	No Information
1	None
2	Occasional
3	Minor interference in functioning
4	Major interference in functioning
5	Gross interference in functioning
6	Grossly unable to function in social and occupational roles

If no current alcohol problem, determine if alcohol section in Part II can be rated without further questions

DRUG ABUSE

0	No information
1	None
2	Clinically insignificant
3	Minor interference
4	Moderate interference
5	Frequent interference
6	Major disruption

If no current problem, determine if Drug Abuse section in Part II can be rated without further questions

ANTISOCIAL BEHAVIOUR

0	No information
1	None
2	Occasional insignificant
3	Occasional significant
4	Frequent significant
5	Frequent serious
6	Major activity

Suspiciousness

0	No information
1	None
2	Slight distrust
3	Definitely suspicious but infrequent
4	Often suspicious
5	Pervasive suspiciousness
6	Clearcut delusions
7	Preoccupations with delusions

Past 2 weeks: 0 1 2 3 4 5 6 7

Ideas of reference

0	No information
1	Absent
2	Suspected
3	Definite

DELUSIONS

☐ **If there is no evidence to suggest delusions, tick here and skip to Hallucinations**

Delusions of reference

0	No information
1	Absent
2	Suspected
3	Definite

Delusions of control

0	No information
1	Absent
2	Suspected
3	Definite

Delusions of mind being read

0	No information
1	Absent
2	Suspected
3	Definite

Thought broadcasting

0	No information
1	Absent
2	Suspected or likely
3	Definite

Thought insertion

0	No information
1	Absent
2	Suspected or likely
3	Definite

Thought withdrawal

0	No information
1	Absent
2	Suspected or likely
3	Definite

Persecutory delusions	**0** **1** **2** **3**
Delusions of jealousy	**0** **1** **2** **3**
Delusions of guilt or sin	**0** **1** **2** **3**
Grandiose delusions	**0** **1** **2** **3**
Somatic delusions	**0** **1** **2** **3**

CHARACTERISTICS OF DELUSIONS REGARDLESS OF TYPE

Severity	**0**	**No information**
	1	**None**
	2	**Suspected**
	3	**Present with insight**
	4	**Present, not influenced**
	5	**Present and influencing**
	6	**Dominating**
	Past 2 weeks: 0 1 2 3 4 5 6	
Sensorium while deluded	**0**	**No information**
	1	**Clear**
	2	**Perplexed**
	3	**Disturbed**
Delusions excluding persecutory or jealousy lasting at least 1 week	**0**	**No information**
	1	**Absent**
	3	**Suspected**
	4	**Definite**
Synthymia	**0**	**No information**
	1	**None**
	2	**Possibly connected**
	3	**Completely connected**

Bizarre quality of delusion	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Multiple delusions	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**
Fragmentory delusions	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**

HALLUCINATIONS

☐ **If there is no evidence to suggest hallucinations, tick here and skip to Bizarre Behaviour**

Experienced auditory hallucinations of voices, noises (not name being called)	**0**	**No information**
	1	**Absent**
	2	**Suspected or likely**
	4	**Definite**
Auditory hallucinations (running commentary on thoughts as they occur)	**0**	**No information**
	1	**Absent**
	2	**Suspected or likely**
	4	**Definite**
Auditory hallucinations in which 2 or more voices converse	**0**	
	1	
	2	
	3	
Non-affective verbal hallucinations spoken to the subject	**0**	
	1	
	2	
	3	
Visual hallucinations	**0**	
	1	
	2	
	3	

Olfactory hallucinations	**0**	
	1	
	2	
	3	
Somatic or tactile hallucinations	**0**	
	1	
	2	
	3	
Grandiose or persecutory content	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**

CHARACTERSITICS OF HALLUCINATIONS OF ANY TYPE

Severity	**0**	**No information**
	1	**None**
	2	**Suspected**
	3	**Present but ignored**
	4	**Present but not influencing**
	5	**Present and influencing**
	6	**Dominating**
	Past 2 weeks: 0 1 2 3 4 5 6	
Mood congruence	**0**	**No information**
	1	**None**
	2	**Possibly**
	3	**Completely**
Fragmentory hallucinations	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**
Sensorium when hallucinating	**0**	**No information**
	1	**Clear**
	2	**Perplexed**
	3	**Clouded**
Hallucinations for 1 week with delusions	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**
Duration of hallucinations	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Definite**

Non affective hallucinations

0 No information
1 Absent
2 Suspected
3 Definite

Bizarre behaviour

0 No information
1 None
2 Odd behaviour not significant
3 Strange behaviour not significant
4 1 instance of 'crazy' behaviour
5 Several instances of 'crazy' behaviour
6 Much of behaviour is 'crazy'

Catatonic motor behaviour

Stupor
Rigidity
Waxy flexibility
Excitement
Posturing

Memory or Orientation disturbance

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Impairment of functioning

0 No information
1 None
2 Minor
3 Significant
4 Important
5 Major
6 Disruptive

Past 2 weeks: 0 1 2 3 4 5 6

ADDITIONAL BEHAVIOURAL ITEMS

Flight of ideas

0 No information
1 None
2 Slight
3 Mild
4 Moderate
5 Severe
6 Extreme

Past 2 weeks: 0 1 2 3 4 5 6

Inappropriate affect	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Blunted affect	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Distractibility	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Self pity	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Dependency	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Depressed appearance	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**

SELECTED SUBTYPES OF FORMAL THOUGHT DISORDER

Severity	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Marked**
	6	**Extreme**
Loosening of association	**0**	**No information**
	1	**None**
	2	**Doubtful**
	3	**Occasional**
	4	**Frequent**
	5	**Very frequent**
	6	**All the time**
Illogical thinking	**0**	**No information**
	1	**None**
	2	**Doubtful**
	3	**Occasional**
	4	**Definite**
	5	**Marked**
	6	**Mostly illogical**
Poverty of content	**0**	**No information**
	1	**None**
	2	**Slight**
	3	**Mild**
	4	**Moderate**
	5	**Severe**
	6	**Extreme**
Neologism	**0**	**No information**
	1	**Absent**
	2	**Suspected**
	3	**Present**

GLOBAL ASSESSMENT SCALE: Rate the subject's lowest level of functioning for the time periods specified. Use intermediary levels when appropriate (e.g. 35, 58, 62). Rate functioning and degree of psychopathology regardless of treatment or prognosis.

Rating for condition at its worst during current episode .....

Rating for condition during past two weeks .....

100 – 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No symptoms.**
90 – 81	**Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and 'everyday' worries and problems that only occasionally get out of hand.**
80 – 71	**No more than slight impairment in functioning, varying degrees of 'everyday' worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.**
70 – 61	**Some mild symptoms (eg depressed mood and mild insomnia) or some difficulty in several areas of functioning, but generally functioning pretty well,has some meaningful interpersonal relationships and most untrained people would not consider him 'sick'.**
60 – 51	**Moderate symptoms or generally functioning with some difficulty (e.g. few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behaviour)**
50 – 41	**Any serious symptomology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behaviour, compulsive drinking, mild but definite manic symptoms).**
40 – 31	**Major impairment in several areas, such as work, family relations, judgement, thinking or mood (e.g. depressed woman avoids friends, neglects family, unable to do housework), or some impairment in reality testing or communication (e.g. speech at times obscure, illogical or irrelevant), or single auicide attempt.**
30 –21	**Unable to function in almost all areas (eg stays in bed all day) or behaviour is considerably influenced by delusions or hallucinations or serious impairment in communication (e.g. sometimes incoherent or unresponsive) or judgement (e.g. acts grossly inappropriate).**
20 – 11	**Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g. repeated suicide attempts, frequently violent, manic excitement, smears faeces), or gross impairment in communication (e.g. largely incoherent or mute)**
10 – 1	**Needs constant supervision for several days to prevent hurting self or others or makes no attempt to maintain minimal personal hygiene or serious suicide act with clear intent and expectation of death**

SADS Part II –

Background Info

Now I would like to ask you some questions about your past

1. Where were you born?
2. How far did you get in school?
3. Did you have any special training?

Friends

4. When you were in your teens , how much time did you spent with your friends?
5. Did you have many close friends?

Marital Status

6. Have you ever been married? – living with partner for more than a year?
7. How many times?

Work experience

8. What kinds of work have you done?
9. Was there any time when you were out of work? – due to your own probs.difficulties?

Overview of past psychiatric Disturbance

10. Have you seen anyone else for emotional problems, your nerves, or the way you were feeling before?
11. Whom did you see?
12. What kinds of probs were you having?
13. Any other times?
14. How old were you when you first saw someone for..?
15. Were you ever a patient in a psychiatric hospital or ward?, how many times, age?
16. Were there any other times when you or someone else felt you needed help because of your nerves, or the way you felt?

Episode of Major Depressive Syndrome

17. Did you ever have a period that lasted 1 week when you were bothered by feeling depressed, sad, blue, hopeless, down in the dumps, that you didn't care or didn't enjoy things?
18. What about feeling irritable or easily annoyed?
19. During teat time did you ever seek help from anyone, like a doctor, friend, or did anyone suggest that you seek help? Or did you take any medication?

20. During the most severe period were you bothered by…..

Poor appetite or weight loss or increase appetite and weight gain?
Trouble sleeping or sleeping too much?
Loss of energy, easily fatigued or feeling tired?
Loss of interest or pleasure in your usual activities
Feeling guilty or down on yourself?
Trouble concentrating, thinking or making decisions?
Thinking about death or suicide?
Being unable to sit and have to keep moving or the opposite, feeling slowed down and have trouble moving?

21.How many episodes have you had like this?

Other Characteristics

22. Number of episodes?
23. How old were you when you had your first?
24. When was the last time you were…?
25 What was the longest time that it lasted?
26 During any of thee episodes were you
Hospitalized
ECT
Received medication

27. Were you able to look after yourself, i.e dress self, feed self?
28. Did you ever try to kill yourself?

SCHEDULE FOR AFFECTIVE DISORDERS AND SCHIZOPHRENIA
SADS

PART II

NAME	

Background Information

Schooling	**0**	**No information**
	1	**Graduate with doctorate**
	2	**Graduate with degree**
	3	**Diploma**
	4	**Highers**
	5	**'O' levels/CSE**
	6	**9 years schooling**
	7	**<9 years schooling**
Adolescent friendship patterns	**0**	**No information**
	1	**Superior**
	2	**Very good**
	3	**Good**
	4	**Fair**
	5	**Poor**
	6	**Solitary**
Current marital status	**0**	**No information**
	1	**Single (never married)**
	2	**Married (or living with someone)**
	3	**Widowed**
	4	**Separated**
	5	**Divorced**
Work history	**0**	**No information**
	1	**No time out of work**
	2	**Only a few days to month**
	3	**Up to 6 months**
	4	**Up to 1 year**
	5	**Up to 2 years**
	6	**Up to 3 years**
	7	**Up to 4 years**
	8	**Up to 5 years**
	9	**Has not worked at all**

OVERVIEW OF PAST PSYCHIATRIC DISTURBANCE

Outpatient treatment prior to this episode

0 No information
1 No contact
2 Consultation (brief treatment)
3 6 months treatment
4 Several years of treatment

Age at first outpatient visit _____

Number of psychiatric hospitalisations _____

Age at first hospitalisation _____

Total time in hospital

0 No information
1 Never hospitalised
2 <3 months
3 <1 year
4 <2 years
5 <5 years
6 >5 years

CRITERIA FOR EPISODES OF MANIC SYNDROME

0 No information
1 Never had elevated moods
2 1 period of irritable mood
3 1 or more periods of elevated mood

ii. Symptoms:	No information	No	Yes
Increased activity	X	1	2
Pressure of speech	X	1	2
Racing thoughts	X	1	2
Grandiosity	X	1	2
Less sleep	X	1	2
Poor concentration	X	1	2
Indiscrete behaviour	X	1	2

☐ If criterion ii is not met, tick here and skip to Episodes of Major Depressive Syndrome

iii. Hospitalisation

1 No information
2 No
3 Yes

Number of manic episodes _____

Determining if Manic Syndrome met criteria for Schizo-affective disorder, Manic Type

Symptoms

Delusions
Hallucinations
- Auditory
- Visual
- Olfactory

Incoherence

☐ **If there is no evidence to suggest delusions, hallucinations, or formal thought disorder as defined in Part I during manic periods tick here and skip to Other Characteristics of episodes of Manic Syndrome**

	No information	No	Yes
Delusions of control	X	1	2
Non-affective hallucinations	X	1	2
1st rank auditory hallucinations	X	1	2
Delusions/hallucinations in absence of mood change	X	1	2

Other characteristics of episodes of manic syndrome

Best estimate of number of episodes	**Manic** _____	**Schizo-aff.** _____
Age at first episode	**Manic** _____	**Schizo-aff.** _____
Age at last episode	**Manic** _____	**Schizo-aff.** _____
Duration of longest episode	**Manic** _____	**Schizo-aff.** _____
Hospitalised	**Yes/No**	**Yes/No**
Received ECT	**Yes/No**	**Yes/No**
Received Medication	**Yes/No**	**Yes/No**
Suicide attempt	**Yes/No**	**Yes/No**

Episodes of Major Depressive Syndrome

i. Depressed or irritable mood

0	**No information**
1	**No**
2	**Yes**

ii. Sought help or referred for help

0	**No information**
1	**No**
2	**Yes**

iii. Had 3 symptoms:	**No information**	**No**	**Yes**
Poor appetite/weight loss	X	1	2
Poor sleep	X	1	2
Fatigue	X	1	2
Anhedonia	X	1	2
Guilt	X	1	2
Poor concentration	X	1	2
Suicidal thoughts	X	1	2
Restlessness	X	1	2

☐ **If criteria iii was not met, tick here and skip to Non-affective Non-organic Psychosis**

Number of episodes _____

Determining if episode of Major Depressive Syndrome met criteria for Schizo-affective disorder, Depressed Type

Symptoms: **Delusions**
Hallucinations – auditory/visual/olfactory
Incoherence

☐ **If there is no evidence to suggest delusions, hallucinations, or marked formal thought disorder as defined in Part I during episodes of Major Depressive Syndrome tick here and go to Other Characteristics of Major Depressive Syndrome**

	No information	No	Yes
Delusions of control	X	1	2
Non affective hallucinations	X	1	2
1st rank hallucinations	X	1	2
Delusions/hallucinations without mood change	X	1	2
Psychotic preoccupation	X	1	2
Thought disorder	X	1	2

Other characteristics of episodes of Major depressive Disorder

	Major Dep. D.	Schizo-aff. D.
Estimated number of episodes	_____	_____
Age at first episode	_____	_____
Age at last episode	_____	_____
Duration of longest episode	_____	_____
Hospitalised	YES/NO	YES/NO
Received ECT	YES/NO	YES/NO
Received medication	YES/NO	YES/NO
Presence of mania	YES/NO	YES/NO
Delusions	YES/NO	YES/NO
Hallucinations	YES/NO	YES/NO
Incapacity	YES/NO	YES/NO
Suicide attempt	YES/NO	YES/NO
Associated with pregnancy/childbirth	YES/NO	YES/NO
Menopause	YES/NO	YES/NO
Apparently followed medication	YES/NO	YES/NO
Apparently followed physical illness	YES/NO	YES/NO

Characteristics of non-affective non-organic psychosis

	Schizo.	Unspecified psychosis
Best estimate of episode		
Age at first episode		
Age at last episode		
Duration of longest episode		
Hospitalised		
Received ECT		
Received medication		
Delusions of any type		
Persecutory delusions		
Delusions – not persecutory or jealousy		
Delusions of control		
Delusions accompanied by hallucinations		
Hallucinatons		
○ **Visual**		
○ **Auditory**		
○ **1st rank**		
Non affective verbal hallucinations		
Thought broadcasting, insertion or withdrawal		
Formal thought disorder		
Catatonia		
Grossly bizarre behaviour		
Suicide attempt		
Incapacity		
Concurrent pregnancy or childbirth		

ALCOHOLISM

i. Drinking habits	**No informaton**	**No**	**Yes**
Excessive drinking	**X**	**1**	**2**
Family objection to drinking	**X**	**1**	**2**
Loss of control	**X**	**1**	**2**
Prominence/withdrawal prevention	**X**	**1**	**2**
Interferes with life	**X**	**1**	**2**
Job loss	**X**	**1**	**2**
Relationship problems	**X**	**1**	**2**
Divorce (separation)	**X**	**1**	**2**
Binges	**X**	**1**	**2**
Violence while drunk	**X**	**1**	**2**
Traffic violation	**X**	**1**	**2**
Civil disturbance	**X**	**1**	**2**
Memory problems	**X**	**1**	**2**
Tremors	**X**	**1**	**2**
DT's	**X**	**1**	**2**
Hallucinations	**X**	**1**	**2**
Fits	**X**	**1**	**2**
Other physical complication	**X**	**1**	**2**

Two of the above items

1. **No**
2. **Yes**

Heavy drinking for 1 month	**1.**	**No**
	2.	**Yes**

Has met the 2 criteria for Alcoholism Yes
Currently has a drinking problem Yes
Age started heavy drinking _____
Age stopped heavy drinking _____

DRUG ABUSE OR DEPENDENCE

0	**No information**	**4**	**More serious**
1	**Not at all**	**5**	**Major life change**
2	**Clinically insignificant**	**6**	**Disruption to life**

Type of drugs

Narcotics
Amphetamine-like
Cocaine
Sedative, hypnotics, tranquillisers
Cannabis
Hallucinogens
Solvents

Rating of 4 or above on severity scale	**1.**	**No**
	2.	**Yes**

Currently has drug problem Yes/No

Age first problem with drugs _____

Age stopped drug use _____

HYPOMANIC EPISODES

i.

0	**No information**
1	**No**
2	**Irritable mood only**
3	**Elevated mood**

ii.	**No information**	**No**	**Yes**
Increased activity	**X**	**1**	**2**
Garrulousness	**X**	**1**	**2**
Racing thoughts	**X**	**1**	**2**
Grandiosity	**X**	**1**	**2**
Decreased sleep	**X**	**1**	**2**
Poor concentration	**X**	**1**	**2**
Indiscrete behaviour	**X**	**1**	**2**

Estimate number of episodes _____

Age at first episode _____

Duration of longest episode _____

CYCLOTHYMIC PERSONALITY

i.

0	No information
1	No
2	Yes

ii. Absence of normal mood

0	No information
1	No
2	Yes

iii. Changes in mood

0	No information
1	No
2	Yes

SOMATIZATION DISORDER (BRIQUET'S DISORDER)

0	No information
1	No
2	Yes

		No information	No	Yes
Group 1	Hypochondriasis	X	1	2
Group 2	Conversion symptoms	X	1	2
Group 3	Abdominal problems	X	1	2
Group 4	Menstrual problems	X	1	2
Group 5	Sexual behaviour	X	1	2
Group 6	Locomotor disorder	X	1	2

LABILE PERSONALITY

0	No information
1	No
2	Yes

	No information	No	Yes
Self pity	X	1	2
Over-reaction	X	1	2
Impulsivity	X	1	2
Worthlessness	X	1	2
Poor relationships	X	1	2
Pessimistic	X	1	2

MINOR DEPRESSIVE DISORDER

0	No information
1	No
2	Yes

Sought help

0	No information
1	No
2	Yes

	No information	No	Yes
Appetite/weight	X	1	2
Sleep trouble	X	1	2
Fatigue	X	1	2
Anhedonia	X	1	2
Guilt/worthlessness	X	1	2
Poor concentration	X	1	2
Suicide attempt	X	1	2
Restlessness	X	1	2
Crying	X	1	2
Pessimism	X	1	2
Brooding	X	1	2
Poor self-esteem	X	1	2
Resentment/bitterness	X	1	2
Dependency	X	1	2
Self-pity	X	1	2
Physical complaints	X	1	2

INTERMITTENT DEPRESSIVE DISORDER

Low mood	**0**	**No information**
	1	**No**
	2	**Yes**
Frequency	**0**	**No information**
	1	**No**
	2	**Yes**
Symptoms as for minor depressive disorder	**0**	**No information**
	1	**No**
	2	**Yes**
Help seeking	**0**	**No information**
	1	**No**
	2	**Yes**

PANIC DISORDER

	No information	No	Yes
Panic attacks	X	1	2
Shortness of breath	X	1	2
Chest pain	X	1	2
Choking	X	1	2
Vertigo	X	1	2
Parasthesia	X	1	2
Sweating	X	1	2
Faintness	X	1	2
Terror	X	1	2
Fear of dying, etc.	X	1	2

Panic and 2 symptoms	**1.**	**No**
	2.	**YES**

3 panic attacks

0 No information
1 No
2 Yes

Other anxiety

0 No information
1 No
2 Yes

Tried medication

0 No information
1 No
2 Yes

Has met criteria for Panic Disorder _____

Age when first met criteria _____

Duration of longest attack _____

Stinulus evoking attack _____

GENERALISED ANXIETY DISORDER

0 No information
1 No
2 Yes

Symptoms	No information	No	Yes
Initial insomnia	X	1	2
Body awareness	X	1	2
Tension/tremors	X	1	2
Worry	X	1	2
Restlessness	X	1	2

Sought help

No
Yes

3 criteria _____

Age when first met criteria _____

Duration of longest episode _____

OBSESSIVE COMPULSIVE DISORDER

0 No information
1 No
2 Yes

Sought help

0 No information
1 No
2 Yes

Criteria met _____

Age at which first met _____

Duration of longest episode _____

Predominant symptom _____

PHOBIC DISORDER

0 No information
1 No
2 Yes

Sought help

0 No information
1 No
2 Yes

Criteria met _____

Age when first met _____

Duration of longest episode _____

Type of phobia

Agarophobia
Social phobia
Simple phobia
Mixed

ANTISOCIAL PERSONALITY

	No information	No	Yes
Frequent job changes	X	1	2
Periods of not working	X	1	2
Absenteeism	X	1	2
Before age 15:			
Truanting	X	1	2
Expelled from school	X	1	2
Poor academic performance	X	1	2
Rule breaking	X	1	2
Court appearance	X	1	2
Ran away from home	X	1	2
Lying	X	1	2
Drinking	X	1	2
Stealing	X	1	2
Vandalism	X	1	2
Sexual precocity	X	1	2
Since age 15:			
Arrests	X	1	2
Divorce	X	1	2
Fighting	X	1	2
Drunkeness	X	1	2
Unpaid debts	X	1	2

No fixed abode	**X**	**1** **2**

Impaired relationships	**0**	**No information**
	1	**No**
	2	**Yes**

PERSONALITY TRAITS

Sensitive	**0**	**No information**
	1	**Not at all**
	2	**Minor extent**
	3	**Moderate**
	4	**Considerable**
	5	**Marked**
	6	**Extreme**

Inhibited	**0**	**No information**
	1	**Not at all**
	2	**To a minor extent**
	3	**Moderate**
	4	**Considerable**
	5	**Marked**
	6	**Extreme**

Extrovert	**0**	**No information**
	1	**Not at all**
	2	**To a minor extent**
	3	**Moderate**
	4	**Considerable**
	5	**Marked**
	6	**Extreme**

OTHER PSYCHIATRIC DISORDER

Schizotypal features	**No information**	**No**	**Yes**
Recurrent illusions	**X**	**1**	**2**
Magical thinking	**X**	**1**	**2**
Ideas of reference	**X**	**1**	**2**
Emotional coolness	**X**	**1**	**2**
Odd communication	**X**	**1**	**2**
Social isolation	**X**	**1**	**2**

PRIMARY/SECONDARY DISTINCTION WITHIN MAJOR DEPRESSIVE DISORDER

Suicidal behaviour	**0**	**No information**
	1	**No**
	2	**Yes**

Suicidal intent	**0**	**No information**
	1	**No intent**
	2	**Not sure**
	3	**Ambivalent**
	4	**Serious**
	5	**Very serious**

	6	Extreme
Medical lethality	0	No information
	1	None
	2	Minimal
	3	Mild
	4	Moderate
	5	Severe
	6	Extreme
SOCIAL FUNCTIONING	0	No information
	1	Superior
	2	Very good
	3	Good
	4	Fair
	5	Poor
	6	Very poor
	7	Grossly inadequate

5,6,7, - Characteristic of functioning during most of his life
- Apparently the result of deterioration of functioning

Levels of functioning	0	No information
	1	Absent symptoms
	2	Trivial symptoms
	3	Mild symptoms
	4	Moderate symptoms
	5	Severe symptoms
	6	Grossly disorganised
Outcome	0	No information
	1	Recovery
	2	Residual impairment
	3	Considerable impairment
	4	Marked deterioration
Currently not mentally ill	0	No information
	1	No
	2	Yes
Never mentally ill	0	No information
	1	No
	2	Yes

SADS Part II

Other Questions

Panic Attacks

Some people have panic attacks when they suddenly feel very frightened and have physical symptoms like palpitations, shortness of breath, and chest pains
Have you had this?
What were they like?
When do they happen?

Did you have;

Shortness of breath
Palpitations
Chest pain
Choking feeling
Dizziness
Tingling
Faintness
Sweating
Trembling, shaking
Fear of dying, going mad, losing mind

How many attacks altogether have you had?
How many last week?
Were you nervous or anxious between attacks?

Somatic Anxiety

Other than when you have had the panic attacks have you been bothered by physical symptoms like palpitations, shortness of breath, sweating, headaches, stomach cramps or muscle tension?

What about during the past week?

Psychic Anxiety

(Other than when you have had these panic attacks) how anxious, frightened, scared or apprehensive have you felt?

How often have you felt this way?

How bad has it gotten?

What about during the past week?

Phobia

Do you have any specific fears of objects, situations, or activities – like crowds, certain animals. Heights, being alone, being closed in, going out alone or certain ways of travelling?

Does the anxiety go away if you can (get away or avoid doing it)?

What effect does this fear have on your life?

What about during the past week?

Obsessions or Compulsions

How about being bothered by thoughts that kept coming back to you that didn't make any sense, that you couldn't get rid of or put out of your mind?

Have you ever had to repeat some act over and over again which you couldn't resist repeating…….like constantly washing your hands, counting things or checking things?

What about during the past week?

APPENDIX SEVEN:

CASE RECORD FILE

CONFIDENTIAL

PATIENT ID No.

PATIENT INITIALS:

LATE LIFE DEPRESSION PROJECT

A RANDOMISED CONTROLLED TRIAL OF COGNITIVE BEHAVIOUR THERAPY VERSUS TREATMENT AS USUAL IN THE TREATMENT OF MILD TO MODERATE LATE LIFE DEPRESSION

CASE RECORD FORM

BASELINE, IN TREATMENT AND OUTCOME ASSESSMENTS

LATE LIFE DEPRESSION PROJECT

INCLUSION/EXCLUSION CRITERIA

NAME:	DATE:

INCLUSION CRITERIA (must answer yes to all)

1. DSM IV criteria for Major Depressive Disorder	**YES**	**NO**
2. BDI score between 14 to 28	**YES**	**NO**
3. HRS-D score between 7 to 24	**YES**	**NO**
4. Age between 60 to 89 years	**YES**	**NO**
5. Informed consent given	**YES**	**NO**

EXCLUSION CRITERIA (must answer no to all)

1. Currently taking anti-depressant medication – must have been without anti-depressant medication for 3 months	**YES**	**NO**
2. Currently receiving systematic psychological therapy	**YES**	**NO**
3. BDI score of 28 or above	**YES**	**NO**
4. HRS-D score of 25 or above	**YES**	**NO**
5. Evidence of psychotic symptoms, or organic pathology (MMSE <22), or currently receiving ECT for late life depression	**YES**	**NO**

LATE LIFE DEPRESSION PROJECT

BASELINE ASSESSMENT

NAME:	DATE:

1. **MEDICATION HISTORY** – ask patient to list current medication, check contents of list against inventory of antidepressants. ☐
2. **BDI II** – patient self report ☐
3. **HRS-D** – completed by research assistant ☐
4. **MMSE** – administered by research assistant ☐
5. **GDS** – patient self report ☐
6. **SADS** – administered by research assistant ☐
7. **BHS** – patient self report ☐
8. **DAS** – patient self report ☐
9. **ATQ** – patient self report ☐
10. **PSWI** – patient self report ☐
11. **QOL-BRF** – patient self report ☐
12. **NART** – administered by research assistant ☐
13. **CSRI** – completed by patient ☐
14. **CONSENT FORM** – go over this with the patient and ask them to sign it ☐
15. **IN TREATMENT ASSESSMENT** – inform patient of procedure for 6 wk and 12 wk assessments ☐

LATE LIFE DEPRESSION PROJECT

MEDICATION HISTORY

Are you currently taking any medication? YES/NO

If YES, what is the name of the medication

Medication	How long been taking

*Patients are excluded if they are currently taking antidepressant medication of have taken antidepressant medication within the past 3 months

MEDICAL HISTORY

Are you currently suffering from physical illness? YES/NO

If YES, what is the name of this condition

LATE LIFE DEPRESSION PROJECT

Tricyclic and related antidepressant drugs	
Generic name	**Proprietary name**
Amitriptyline Hydrochloride	Lentizol Tryptizol Triptafen Triptafen-M
Amoxapine	Asendis
Clomipramine Hydrochloride	Clomipramine Anafranil Anafranil SR
Dothiepin Hydrochloride	Dothiepin Prothieden
Doxepin	Sinequan
Imipramine Hydrochloride	Imipramine Tofranil
Loferpramine	Loferpramine Gamanil
Nortriptyline	Allegron Motipress Motival
Protriptyline Hydrochloride	Concordin
Trimipramine	Surmontil
Maprotiline Hydrochloride	Ludiomil
Mianserin Hydrochloride	Mianserin
Mirtazepine	Zispin
Trazodone Hydrochloride	Molipaxin
Viloxazine Hydrochloride	Vivalan

SSRI's and related antidepressants	
Generic name	**Proprietary name**
Citalopram	Cipramil
Fluoxetine	Prozac
Fluvoxamine	Faverin
Paroxetine	Seroxat
Sertraline	Lustral
Nefazodone Hydrochloride	Dutonin
Venlafaxine	Efexor Efexor XL

Monoamine-oxidase inhibitors (MAOI's)	
Generic name	**Proprietary name**
Phenelzine	Nardil
Isocarboxazid	Isocarboxazid
Tranylcypramine	Parnate Parstelin
Moclobemide	Manerix

Other antidepressant drugs	
Generic name	**Proprietary name**
Reboxetine	Edronax
Tryptophan	Optimax

BDI®-II

Date:

_____ Marital Status: _____ Age: _____ Sex: _____

ation: _____ Education: _____

ctions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and ck out the **one statement** in each group that best describes the way you have been feeling during the **past two , including today**. Circle the number beside the statement you have picked. If several statements in the group o apply equally well, circle the highest number for that group. Be sure that you do not choose more than one ent for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

adness

I do not feel sad.

I feel sad much of the time.

I am sad all the time.

I am so sad or unhappy that I can't stand it.

essimism

I am not discouraged about my future.

I feel more discouraged about my future than I used to be.

I do not expect things to work out for me.

I feel my future is hopeless and will only get worse.

ast Failure

I do not feel like a failure.

I have failed more than I should have.

As I look back, I see a lot of failures.

I feel I am a total failure as a person.

ss of Pleasure

I get as much pleasure as I ever did from the things I enjoy.

I don't enjoy things as much as I used to.

I get very little pleasure from the things I used to enjoy.

I can't get any pleasure from the things I used to enjoy.

ilty Feelings

I don't feel particularly guilty.

I feel guilty over many things I have done or should have done.

I feel quite guilty most of the time.

I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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gitation

I am no more restless or wound up than usual.

I feel more restless or wound up than usual.

I am so restless or agitated that it's hard to stay still.

I am so restless or agitated that I have to keep moving or doing something.

oss of Interest

I have not lost interest in other people or activities.

I am less interested in other people or things than before.

I have lost most of my interest in other people or things.

It's hard to get interested in anything.

decisiveness

I make decisions about as well as ever.

I find it more difficult to make decisions than usual.

I have much greater difficulty in making decisions than I used to.

I have trouble making any decisions.

orthlessness

I do not feel I am worthless.

I don't consider myself as worthwhile and useful as I used to.

I feel more worthless as compared to other people.

I feel utterly worthless.

oss of Energy

I have as much energy as ever.

I have less energy than I used to have.

I don't have enough energy to do very much.

I don't have enough energy to do anything.

anges in Sleeping Pattern

I have not experienced any change in my sleeping pattern.

I sleep somewhat more than usual.

I sleep somewhat less than usual.

I sleep a lot more than usual.

I sleep a lot less than usual.

I sleep most of the day.

I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

Hamilton Depression Scale – 17 (HAM-D)

Client Name: _____ **Date:** _____

***Instructions*: Circle one number per item. Score all items.**

1. **Depressed Mood (sad, blue, gloomy, weepy, pessimistic, helpless, hopeless, worthless)**
   - 0 Not depressed
   - 1 Feeling states elicited only on questioning
   - 2 Occasional weeping or spontaneously reports feeling states.
   - 3 Frequent weeping. Obvious behavioural evidence in facies, posture, voice. Speaks mostly about feeling states.
   - 4 Exhibits virtually only these feeling states verbally and nonverbally. May have "gone beyond weeping".

2. **Guilt feelings and delusions**
   - 0 Absent
   - 1 Self-reproach, feels he/she has let people down
   - 2 Expresses guilt over past errors
   - 3 Present illness is deserved punishment. Ruminations over past errors and sins.
   - 4 Severe self-reproach. Guilty delusions e.g. is making other people ill. Deserves to die. May have accusatory or denouncing auditory or visual hallucinations.

3. **Suicide**
   - 0 Absent
   - 1 Feels life is empty, not worth living
   - 2 Recurrent thoughts or wishes about death of self
   - 3 Active suicidal thoughts, threats, gestures
   - 4 Serious suicide attempt

4. **Initial Insomnia (as part of present illness)**
   - 0 Absent
   - 1 Mild, infrequent, less than ½ hour
   - 2 Obvious and severe, more than ½ hour usually

5. **Middle Insomnia**
   - 0 Absent (Rate 1 if hypnotic is being used)
   - 1 Complains of feeling restless and disturbed during night
   - 2 Wakes during the night: any reading or smoking in bed or getting out of bed except to void.

6. **Delayed Insomnia**
   - 0 Absent
   - 1 Wakes earlier than usual
   - 2 Wakes 1 – 3 hours before usual, unable to sleep again.

7. **Work and Activities (Apathy: loss of interest in work, hobbies, social life. Anhedonia: unable to feel pleasure)**
   - 0 No disturbance
   - 1 Feels incapable, listless, less efficient. (Rate fatigue, loss of energy under item 13)
   - 2 Has to push self to work or play. No active interests, gets little satisfaction, feels listless, indecisive.
   - 3 Clearly decreased efficiency. Spends less time at usual work.
   - 4 Stopped work because of present illness. Doesn't shave, bathe etc. Works only with urging.

8. **Retardation (psychomotor slowing of thought, speech, and movement)**
   - 0 Absent
   - 1 Slight flattened affect, fixed facial expression
   - 2 Monotonous voice, delayed answering, sits motionless
   - 3 Interview difficult and prolonged. Moves slowly.
   - 4 Depressive stupor. Interview impossible.

Hamilton Depression Scale – 17 (HAM-D)

9. Agitation (may co-exist mildly with retardation)

0 None
1 Fidgety
2 Playing with hands or hair, picking at hands or clothes
3 Moving about, can't sit still
4 Hand wringing, nail biting, hair pulling, biting of lips.

10. Psychic Anxiety (as part of present illness, NOT part of previous disposition. Includes feeling tense, irritable, apprehensive, fearful, phobic or panic attacks).

0 Absent
1 Minimal distress, admitted only on direct questioning.
2 Spontaneously expresses discomfort; worries over trivia.
3 Obviously apprehensive in face of speech.
4 Severely anxious, panicky.

11. **Somatic Anxiety (physiological concomitants of anxiety such as: fainting, tinnitus, blurred vision, headache, tremor, sweating, flushing, hyperventilation, palpitations, indigestion, belching, diarrhoea, urinary frequency**).

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

12. Somatic Symptoms Gastrointestinal

0 Normal appetite
1 East spontaneously but without relish
2 Marked reduction of appetite and food intake. Eats only with urging. Requests or requires laxatives.

13. Somatic energy

0 Normal
1 Occasional mild fatigue, easy tiring, aching.
2 Obviously low in energy, tired all the time: frequent backaches, headaches, heavy feelings in limbs

14. Genital Symptoms (rate change in libido, impotence, menstrual disturbances)

0 Absent
1 Mild
2 Severe

15. Hypochondriasis

0 Absent
1 Self-absorbed about bodily functions and physical symptoms
2 Preoccupied with health
3 Frequent complaints, requests for help etc.
4 Morbid convictions of organic disease e.g. brain tumour, cancer, or delusion e.g. worms eating head getting inside, bowels blocked, terrible odour

16. Weight loss (when rated by history, according to subject)

0 No weight loss
1 Probable weight loss
2 Definite weight loss

17. Loss of Insight

0 Acknowledges being depressed
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

M.M.S.E. : A. A. H.

-me: Date:

IENTATION : Score 1 point for each correct answer to following.

ıe?	Date ?	Day ?	Month ?	Year ?	( )
rd ?	Hospital ?	District ?	Town ?	Country ?	( )

GISTRATION : Examiner names 3 objects. Score up to 3 points if, on the first attempt, the ient repeats, in order, the 3 objects. Score 2 or 1 if this is the number of objects he repeats rectly. Use further attempts & prompting to have all 3 repeated, so as to test recall later. ( )

TENTION & CALCULATION : Ask the patient to subtract 7 from 100, then 7 from the ult - repeat this 5 times, scoring 1 for each correct subtraction. (max. score 5 points) ( )

CALL : Ask for the 3 objects in the registration test scoring 1 point for each. ( )

NGUAGE : Score 1 point for each of 2 objects (a pen & a watch) correctly named. ( )

Score 1 point for the correct repetition of this phrase
"No ifs, ands or buts" ( )

Score 3 if a three-stage command is correctly executed or 1 for each stage (e.g., "with the index finger of your right hand touch the tip of your nose & then your left ear") ( )

On a blank piece of paper write "CLOSE YOUR EYES".
Ask the patient to obey. Score 1 point. ( )

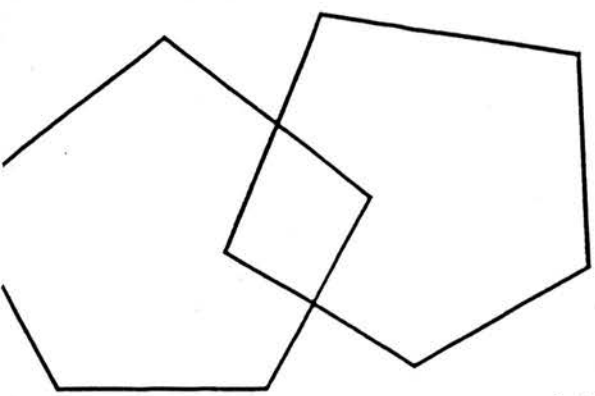
Ask the patient to write one short sentence with a subject and a verb. ( )

NSTRUCTION & SPATIAL SENSE : Construct a pair of intersecting pentagons each 1 ince long (see below). Score 1 if this is correctly copied. ( )

TOTAL SCORE (maximum 30) ( )

(From Dick et al J. Neurol Neurosurg Psychiatry 1984; 47 : 496-9)

authors suggest that score of 23 or less is "suggestive cognitive impairment". It is also not very sensitive to t hemisphere damage.



LATE LIFE DEPRESSION PROJECT

G. D. SCREENING SCALE (YESAVAGE)
(SHORT FORM)

NAME:	DATE:

Please answer all the following questions by ringing either 'YES' or 'NO'

1. Are you basically satisfied with your life?	**YES/ NO**
2. Have you dropped many of your activities and interests?	**YES /NO**
3. Do you feel that your life is empty?	**YES//NO**
4. Do you often get bored?	**YES/NO**
5. Are you in good spirits most of the time?	**YES/ NO**
6. Are you afraid that something bad is going to happen to you?	**YES/NO**
7. Do you feel happy most of the time?	**YES/NO**
8. Do you often feel helpless?	**YES/NO**
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES/NO**
10. Do you feel you have more problems with memory than most?	**YES/NO**
11. Do you think it is wonderful to be alive now?	**YES/NO**
12. Do you feel pretty worthless the way you are now?	**YES/NO**
13. Do you feel full of energy?	**YES/NO**
14. Do you feel that your situation is hopeless?	**YES/NO**
15. Do you think that most people are better off than you?	**YES/NO**

BHS

Date:_____

me:_____ Marital Status:_____ Age:_____ Sex:_____

cupation:_____ Education:_____

's questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement cribes your attitude for the **past week including today,** darken the circle with a 'T' indicating TRUE in the umn next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' icating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	Ⓣ Ⓕ
2.	I might as well give up because there is nothing I can do about making things better for myself.	Ⓣ Ⓕ
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	Ⓣ Ⓕ
4.	I can't imagine what my life would be like in ten years.	Ⓣ Ⓕ
5.	I have enough time to accomplish the things I want to do.	Ⓣ Ⓕ
6.	In the future, I expect to succeed in what concerns me most.	Ⓣ Ⓕ
7.	My future seems dark to me.	Ⓣ Ⓕ
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	Ⓣ Ⓕ
9.	I just can't get the breaks, and there's no reason I will in the future.	Ⓣ Ⓕ
10.	My past experiences have prepared me well for the future.	Ⓣ Ⓕ
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	Ⓣ Ⓕ
12.	I don't expect to get what I really want.	Ⓣ Ⓕ
13.	When I look ahead to the future, I expect that I will be happier than I am now.	Ⓣ Ⓕ
14.	Things just don't work out the way I want them to.	Ⓣ Ⓕ
15.	I have great faith in the future.	Ⓣ Ⓕ
16.	I never get what I want, so it's foolish to want anything.	Ⓣ Ⓕ
17.	It's very unlikely that I will get any real satisfaction in the future.	Ⓣ Ⓕ
18.	The future seems vague and uncertain to me.	Ⓣ Ⓕ
19.	I can look forward to more good times than bad times.	Ⓣ Ⓕ
20.	There's no use in really trying to get anything I want because I probably won't get it.	Ⓣ Ⓕ

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DAS – 24 (Power et al, 1994)

This scale lists different attitudes or beliefs which people sometimes hold. Please read each statement carefully and decide how much you **agree or disagree** with what it says.
For each of the attitudes please indicate your answer by placing a tick under the column that **best describes how you think.** Be sure to choose only one answer for each attitude. But please note that because people are different, there is no right or wrong answer to these statements.
To decide whether a given answer is typical of your way of looking at things, simply keep in mind what you are like **most of the time.**

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
I fail partly, it is as as being a complete ure.							
others dislike you, cannot be happy.							
should be happy all time.							
eople will probably k less of me if I make istake.							
ly happiness depends e on other people it does on me.							
should always have plete control over my ngs.							
ly life is wasted ss I am a success.							
/hat other people k about me is very ortant							
ought to be able to e my problems kly and without a t deal of effort.							
f I don't set the est standards for elf, I am likely to end second rate person.							
am nothing if a on I love doesn't love							
A person should be to control what pens to him.							

DAS – 24 (Contd)

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
If I am to be a thwhile person, I st be truly standing in at least major aspect.							
If you don't have er people to lean on, are bound to be sad.							
It is possible for a son to be scolded and get upset.							
I must be a useful, ductive, creative son or life has no pose.							
I can find happiness hout being loved by ther person.							
A person should do at everything he ertakes.							
f I do not do well all time, people will not ect me.							
do not need the roval of other people rder to be happy.							
f I try hard enough, uld be able to excel at ything I attempt.							
People who have l ideas are more thy than those who ot.							
A person doesn't l to be well liked in er to be happy.							
Whenever I take a nce or risk I am only ing for trouble.							

ATQ

AME _____ Date _____

sted below are a variety of thoughts that pop into people's heads. Please read each thought d indicate how frequently, if at all, the thoughts occurred to you over the last two weeks. ease read each item carefully and circle the appropriate answers on the answer sheet in the lowing fashion.

= not at all 2 = sometimes 3 = moderately often 4 = often 5 = all the time

	Items	Response				
	I feel like I'm up against the world	1	2	3	4	5
	I'm no good	1	2	3	4	5
	Why can't I ever succeed?	1	2	3	4	5
	No-one understands me	1	2	3	4	5
	I've let people down	1	2	3	4	5
	I don't think I can go on	1	2	3	4	5
	I wish I were a better person	1	2	3	4	5
	I'm so weak	1	2	3	4	5
	My life's not going the way I want it to	1	2	3	4	5
0	I'm so disappointed in myself	1	2	3	4	5
	Nothing feels good any more	1	2	3	4	5
2	I can't stand this any more	1	2	3	4	5
3	I can't get started	1	2	3	4	5
	What's wrong with me?	1	2	3	4	5
5	I wish I were somebody else	1	2	3	4	5
6	I can't get things together	1	2	3	4	5
	I hate myself	1	2	3	4	5
8	I'm worthless	1	2	3	4	5
9	I wish I could just disappear	1	2	3	4	5
0	What's the matter with me?	1	2	3	4	5
	I'm a loser	1	2	3	4	5
2	My life is a mess	1	2	3	4	5
	I'm a failure	1	2	3	4	5
	I'll never make it	1	2	3	4	5
	I feel so helpless	1	2	3	4	5
	Something has to change	1	2	3	4	5
	There must be something wrong with me	1	2	3	4	5
	My future is bleak	1	2	3	4	5
	It's just not worth it	1	2	3	4	5
	I can't finish anything	1	2	3	4	5

Automatic Thoughts Questionnaire

Scoring: add up the scores

Typical depressed group mean = 82
Typical control group mean = 42

Reference:

Hollon, S.D. and Kendall, P.C. (1980) Cognitive Self Statements in Depression: Development of Automatic Thoughts Questionnaire. *Cognitive Therapy and Research*, 4, 383-395.

PENNSYLVANIA STATE WORRY INVENTORY

Directions: **A number of statements which people have used to describe themselves are given below. Read each statement and then circle the number below the statement to describe how you generally feel. There are no right or wrong answers. Do not spend too much time on any statement but give the answer which seems to describe how you generally feel.**

1. **If I don't have enough time to do everything, I don't worry about it.**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

2. **My worries overwhelm me.**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

3. **I don't tend to worry about things**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

4. **Many situations make me worry**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

5. **I know I shouldn't worry about things but I just can't help it**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

6. **When I am under pressure I worry a lot**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

7. **I am always worrying about something**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

8. **I find it easy to dismiss worrisome thoughts**

1----------2----------3---------4----------5
not at all typical of me **very typical of me**

PENNSYLVANIA STATE WORRY INVENTORY

9. As soon as I finish one task, I start to worry about everything else I have to do

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

10. I never worry about anything

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

11. When there is nothing more I can do about a concern, I don't worry about it anymore

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

12. I've been a worrier all my life

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

13. I notice that I have been worrying about things

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

14. Once I start worrying, I can't stop

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

15. I worry all the time

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

16. I worry about projects until they are all done

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

WHOQOL-BREF

Field Trial Version
December 1996

PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANISATION
GENEVA

ABOUT YOU

ore you begin we would like to ask you to answer a few general questions about yourself by circling the rect answer or by filling in the space provided

at is your gender? Male Female

at is your date of birth? _____ / _____ / _____
Day Month Year

at is the highest education you received?
None at all
Primary school
Secondary school
Tertiary

at is your marital status?
Single Separated
Married Divorced
Living as married Widowed

you currently ill? Yes No

omething is wrong with your health what do you think it is?
_____ illness/problem

ruction
s questionnaire asks how you feel about your quality of life, health, or other areas of your life. Please wer all the questions.
ou are unsure about which response to give to a question, please choose the one that appears most ropriate. This can often be your first response.

ase keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in last two weeks. For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

u should circle the number that best fits how much support you got from others over the last two weeks. So would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	(4)	5

u would circle number 1 if you did not get any of the support that you needed from others in the last weeks. Please read each question assessment feelings and circle the number of the scale for each stion that gives the best answer for you

		Very poor	Poor	Neither poor nor good	Good	Very good
1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
4)	How satisfied are you with your health?	1	2	3	4	5

e following questions ask about how much you have experienced certain things in the last two weeks

		Not at all	A little	A moderate amount	Very much	An extreme amount
4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
1)	How much do you enjoy life?	1	2	3	4	5
4.2	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
3)	How well are you able to concentrate?	1	2	3	4	5
5.1)	How safe do you feel in your daily life?	1	2	3	4	5
2.1)	How healthy is your physical environment?	1	2	3	4	5

e following questions ask about how completely you experience or were able to do certain things in the two weeks

		Not at all	A little	Moderately	Mostly	Completely
1)	Do you have enough energy for everyday life?	1	2	3	4	5
1)	Are you able to accept your bodily appearance?	1	2	3	4	5
3.1)	Have you enough money to meet your needs?	1	2	3	4	5
0.1)	How available to you is the information that you need in your day to day life?	1	2	3	4	5
.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
1)	How well are you able to get around?	1	2	3	4	5

e following questions ask you to say how good or satisfied you have felt about various aspects of your over the last two weeks

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
3)	How satisfied are you with your sleep?	1	2	3	4	5
3)	How satisfied are you with your ability to perform your daily living activities??	1	2	3	4	5
.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
3)	How satisfied are you with yourself?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
.3)	How satisfied are you with your sex life?	1	2	3	4	5
.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
.3)	How satisfied are you with your access to health services?	1	2	3	4	5
.3)	How satisfied are you with your transport?	1	2	3	4	5

e following question refers to how often you have felt or experienced certain things in the last two eks

		Never	Seldom	Quite often	Very often	Always
1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

l someone help you to fill out this form? .....

w long did it take to fill this form out? .....

you have any comments about the questionnaire? .....

.....

.....

THANK YOU FOR YOUR HELP

office use only _____

	Equations for computing domain scores	Raw score	Transformed score*
ain 1	(6-Q3) + (6-Q4) + Q10) + Q15 + Q16 + Q17 + Q18 ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	
ain 2	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ ☐ ☐ ☐ ☐ ☐	=	
ain 3	Q20 + Q21 + Q22 ☐ ☐ ☐	=	
ain 4	Q8 + Q9 + Q12 + Q13 +Q14 + Q23 +Q24 +Q25 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	

ase see table on page 9 of the manual for converting raw scores to transformed score

National Adult Reading Test (NART)

SECOND EDITION

Answer/Record Sheet

:..... Date of test:.....

	Errors		Errors
CHORD		SUPERFLUOUS	
ACHE		SIMILE	
DEPOT		BANAL	
AISLE		QUADRUPED	
)UQUET		CELLIST	
PSALM		FACADE	
CAPON		ZEALOT	
DENY		DRACHM	
NAUSEA		AEON	
DEBT		PLACEBO	
RTEOUS		ABSTEMIOUS	
RAREFY		DETENTE	
IVOCAL		IDYLL	
NAIVE		PUERPERAL	
ACOMB		AVER	
AOLED		GAUCHE	
THYME		TOPIARY	
HEIR		LEVIATHAN	
RADIX		BEATIFY	
GNATE		PRELATE	
HIATUS		SIDEREAL	
UBTLE		DEMESNE	
REATE		SYNCOPE	
GIST		LABILE	
OUGE		CAMPANILE	

)btained WAIS/WAIS-R results*:

ull scale IQ | Verbal IQ | Performance IQ

'ART error score

	Predicted IQ	Predicted-obtained IQ	Abnormality (%)
Full scale IQ			
Verbal IQ			
Performance IQ			

ART + Schonell error score

	Predicted IQ	Predicted-obtained IQ	Abnormality (%)
Full scale IQ			

)elete as appropriate

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NFER-NELSON
INFORMING YOUR DECISIONS

LATE LIFE DEPRESSION PROJECT

IN TREATMENT ASSESSMENT (6 WEEKS)

Following a priming telephone call the patient will receive by post;

1. **BDI II**
2. **BHS**
3. **STAMPED ADDRESSED ENVELOPE**

The research assistant will phone the patient to determine if they are having any difficulties completing the questionnaires and request the patient to return them.

Date posted	Date returned	Returned complete
		BDI II
		BHS

If the measures are not returned the research assistant will contact the patient and visit if permitted.

LATE LIFE DEPRESSION PROJECT

IN TREATMENT ASSESSMENT (12 WEEKS)

Following a priming telephone call the patient will receive by post;

1. **BDI II**
2. **BHS**
3. **STAMPED ADDRESSED ENVELOPE**

The research assistant will then phone the patient to determine if they are having any difficulties completing the questionnaires and request the patient to return them.

Date posted	Date returned	Returned complete
		BDI II
		BHS

If the measures are not returned the research assistant will contact the patient and visit if permitted.

LATE LIFE DEPRESSION PROJECT

END OF TREATMENT (18 weeks) ASSESSMENT

NAME:	DATE:

1. **BDI II** – patient self report ☐
2. **HRS-D** – completed by research assistant ☐
3. **MMSE** – administered by research assistant ☐
4. **GDS** – patient self report ☐
5. **LIFE-II** – administered by research assistant ☐
6. **BHS** – patient self report ☐
7. **DAS** – patient self report ☐
8. **ATQ** – patient self report ☐
9. **PSWI** – patient self report ☐
10. **QOL-BRF** – patient self report ☐
11. **CSRI** – completed by patient ☐
12. **DATE OF NEXT INTERVIEW** – give patient date of 3 month follow-up assessment ☐

BDI-II

Date:

: _____ Marital Status: _____ Age: _____ Sex: _____

pation: _____ Education: _____

ıctions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and ɔick out the **one statement** in each group that best describes the way you have been feeling during the **past two s, including today**. Circle the number beside the statement you have picked. If several statements in the group to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one ıent for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

Sadness

I do not feel sad.

I feel sad much of the time.

I am sad all the time.

I am so sad or unhappy that I can't stand it.

Pessimism

I am not discouraged about my future.

I feel more discouraged about my future than I used to be.

I do not expect things to work out for me.

I feel my future is hopeless and will only get worse.

Past Failure

I do not feel like a failure.

I have failed more than I should have.

As I look back, I see a lot of failures.

I feel I am a total failure as a person.

oss of Pleasure

I get as much pleasure as I ever did from the things I enjoy.

I don't enjoy things as much as I used to.

I get very little pleasure from the things I used to enjoy.

I can't get any pleasure from the things I used to enjoy.

uilty Feelings

I don't feel particularly guilty.

I feel guilty over many things I have done or should have done.

I feel quite guilty most of the time.

I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

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ıgitation

I am no more restless or wound up than usual.

I feel more restless or wound up than usual.

I am so restless or agitated that it's hard to stay still.

I am so restless or agitated that I have to keep moving or doing something.

.oss of Interest

I have not lost interest in other people or activities.

I am less interested in other people or things than before.

I have lost most of my interest in other people or things.

It's hard to get interested in anything.

ndecisiveness

I make decisions about as well as ever.

I find it more difficult to make decisions than usual.

I have much greater difficulty in making decisions than I used to.

I have trouble making any decisions.

Worthlessness

I do not feel I am worthless.

I don't consider myself as worthwhile and useful as I used to.

I feel more worthless as compared to other people.

I feel utterly worthless.

.oss of Energy

I have as much energy as ever.

I have less energy than I used to have.

I don't have enough energy to do very much.

I don't have enough energy to do anything.

:hanges in Sleeping Pattern

I have not experienced any change in my sleeping pattern.

I sleep somewhat more than usual.

I sleep somewhat less than usual.

I sleep a lot more than usual.

I sleep a lot less than usual.

I sleep most of the day.

I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

E: This form is printed with both blue and black ink. If your es not appear this way, it has been photocopied in of copyright laws.

Hamilton Depression Scale – 17 (HAM-D)

Client Name: _____ **Date:** _____

***Instructions*: Circle one number per item. Score all items.**

1. **Depressed Mood (sad, blue, gloomy, weepy, pessimistic, helpless, hopeless, worthless)**
   - 0 Not depressed
   - 1 Feeling states elicited only on questioning
   - 2 Occasional weeping or spontaneously reports feeling states.
   - 3 Frequent weeping. Obvious behavioural evidence in facies, posture, voice. Speaks mostly about feeling states.
   - 4 Exhibits virtually only these feeling states verbally and nonverbally. May have "gone beyond weeping".

2. **Guilt feelings and delusions**
   - 0 Absent
   - 1 Self-reproach, feels he/she has let people down
   - 2 Expresses guilt over past errors
   - 3 Present illness is deserved punishment. Ruminations over past errors and sins.
   - 4 Severe self-reproach. Guilty delusions e.g. is making other people ill. Deserves to die. May have accusatory or denouncing auditory or visual hallucinations.

3. **Suicide**
   - 0 Absent
   - 1 Feels life is empty, not worth living
   - 2 Recurrent thoughts or wishes about death of self
   - 3 Active suicidal thoughts, threats, gestures
   - 4 Serious suicide attempt

4. **Initial Insomnia (as part of present illness)**
   - 0 Absent
   - 1 Mild, infrequent, less than ½ hour
   - 2 Obvious and severe, more than ½ hour usually

5. **Middle Insomnia**
   - 0 Absent (Rate 1 if hypnotic is being used)
   - 1 Complains of feeling restless and disturbed during night
   - 2 Wakes during the night: any reading or smoking in bed or getting out of bed except to void.

6. **Delayed Insomnia**
   - 0 Absent
   - 1 Wakes earlier than usual
   - 2 Wakes 1 – 3 hours before usual, unable to sleep again.

7. **Work and Activities (Apathy: loss of interest in work, hobbies, social life. Anhedonia: unable to feel pleasure)**
   - 0 No disturbance
   - 1 Feels incapable, listless, less efficient. (Rate fatigue, loss of energy under item 13)
   - 2 Has to push self to work or play. No active interests, gets little satisfaction, feels listless, indecisive.
   - 3 Clearly decreased efficiency. Spends less time at usual work.
   - 4 Stopped work because of present illness. Doesn't shave, bathe etc. Works only with urging.

8. **Retardation (psychomotor slowing of thought, speech, and movement)**
   - 0 Absent
   - 1 Slight flattened affect, fixed facial expression
   - 2 Monotonous voice, delayed answering, sits motionless
   - 3 Interview difficult and prolonged. Moves slowly.
   - 4 Depressive stupor. Interview impossible.

Hamilton Depression Scale – 17 (HAM-D)

9. Agitation (may co-exist mildly with retardation)

0 None
1 Fidgety
2 Playing with hands or hair, picking at hands or clothes
3 Moving about, can't sit still
4 Hand wringing, nail biting, hair pulling, biting of lips.

10. Psychic Anxiety (as part of present illness, NOT part of previous disposition. Includes feeling tense, irritable, apprehensive, fearful, phobic or panic attacks).

0 Absent
1 Minimal distress, admitted only on direct questioning.
2 Spontaneously expresses discomfort; worries over trivia.
3 Obviously apprehensive in face of speech.
4 Severely anxious, panicky.

11. **Somatic Anxiety (physiological concomitants of anxiety such as: fainting, tinnitus, blurred vision, headache, tremor, sweating, flushing, hyperventilation, palpitations, indigestion, belching, diarrhoea, urinary frequency**).

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

12. Somatic Symptoms Gastrointestinal

0 Normal appetite
1 East spontaneously but without relish
2 Marked reduction of appetite and food intake. Eats only with urging. Requests or requires laxatives.

13. Somatic energy

0 Normal
1 Occasional mild fatigue, easy tiring, aching.
2 Obviously low in energy, tired all the time: frequent backaches, headaches, heavy feelings in limbs

14. Genital Symptoms (rate change in libido, impotence, menstrual disturbances)

0 Absent
1 Mild
2 Severe

15. Hypochondriasis

0 Absent
1 Self-absorbed about bodily functions and physical symptoms
2 Preoccupied with health
3 Frequent complaints, requests for help etc.
4 Morbid convictions of organic disease e.g. brain tumour, cancer, or delusion e.g. worms eating head getting inside, bowels blocked, terrible odour

16. Weight loss (when rated by history, according to subject)

0 No weight loss
1 Probable weight loss
2 Definite weight loss

17. Loss of Insight

0 Acknowledges being depressed
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

MENTAL STATE ASSESSMENT

Name **Date**

ORIENTATION: Score 1 point for each correct answer to following

Time? **Date?** **Day?** **Month?** **Year?** (_____)

PM? **Monarch?** **Town?** **District?** **Country?** (_____)

REGISTRATION: Examiner names 3 objects. Score up to 3 points if, on the first attempt, the subject repeats, in order, the 3 objects. Score 2 or 1 if this is the number of objects he repeats correctly. Use further attempts and prompting to have all 3 repeated, so as to test recall later. (_____)

ATTENTION & CALCULATION: Ask the subject to subtract 7 from 100, then 7 from the result – repeat this 5 times, scoring 1 point for each correct subtraction (max. score 5 points). **OR** ask the subject to spell "WORLD" backwards. (_____)

RECALL: Ask for the 3 objects named in the registration test scoring 1 point for each. (_____)

LANGUAGE:
Score 1 point for each of two objects (pen & watch) correctly named. (_____)

Score 1 point for the correct repetition of this phrase (_____)
"No ifs, ands or buts"

Score 3 if a three-stage command is correctly executed or 1 for each stage. **"With the index finger of your right hand touch the tip of your nose and then your left ear"** (_____)

On a blank piece of paper write **"CLOSE YOUR EYES"**. Ask the subject to obey. Score 1 point. (_____)

Ask the subject to write one short sentence with a ***subject*** and a ***verb.*** Score 1 point. (_____)

CONSTRUCTION & SPATIAL SENSE: Construct a pair of intersecting pentagons each side one inch long (see below). Score 1 point if this is correctly copied. (_____)

TOTAL SCORE (maximum 30) (_____)

LATE LIFE DEPRESSION PROJECT

G. D. SCREENING SCALE (YESAVAGE)
(SHORT FORM)

NAME:	DATE:

Please answer all the following questions by ringing either 'YES' or 'NO'

1. Are you basically satisfied with your life?	**YES/ NO**
2. Have you dropped many of your activities and interests?	**YES /NO**
3. Do you feel that your life is empty?	**YES//NO**
4. Do you often get bored?	**YES/NO**
5. Are you in good spirits most of the time?	**YES/ NO**
6. Are you afraid that something bad is going to happen to you?	**YES/NO**
7. Do you feel happy most of the time?	**YES/NO**
8. Do you often feel helpless?	**YES/NO**
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES/NO**
10. Do you feel you have more problems with memory than most?	**YES/NO**
11. Do you think it is wonderful to be alive now?	**YES/NO**
12. Do you feel pretty worthless the way you are now?	**YES/NO**
13. Do you feel full of energy?	**YES/NO**
14. Do you feel that your situation is hopeless?	**YES/NO**
15. Do you think that most people are better off than you?	**YES/NO**

BHS

Date:_____

ame:_____ Marital Status:_____ Age:_____ Sex:_____

cupation:_____ Education:_____

is questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement scribes your attitude for the **past week including today**, darken the circle with a 'T' indicating TRUE in the umn next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' icating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	Ⓣ Ⓕ
2.	I might as well give up because there is nothing I can do about making things better for myself.	Ⓣ Ⓕ
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	Ⓣ Ⓕ
4.	I can't imagine what my life would be like in ten years.	Ⓣ Ⓕ
5.	I have enough time to accomplish the things I want to do.	Ⓣ Ⓕ
6.	In the future, I expect to succeed in what concerns me most.	Ⓣ Ⓕ
7.	My future seems dark to me.	Ⓣ Ⓕ
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	Ⓣ Ⓕ
9.	I just can't get the breaks, and there's no reason I will in the future.	Ⓣ Ⓕ
10.	My past experiences have prepared me well for the future.	Ⓣ Ⓕ
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	Ⓣ Ⓕ
12.	I don't expect to get what I really want.	Ⓣ Ⓕ
13.	When I look ahead to the future, I expect that I will be happier than I am now.	Ⓣ Ⓕ
14.	Things just don't work out the way I want them to.	Ⓣ Ⓕ
15.	I have great faith in the future.	Ⓣ Ⓕ
16.	I never get what I want, so it's foolish to want anything.	Ⓣ Ⓕ
17.	It's very unlikely that I will get any real satisfaction in the future.	Ⓣ Ⓕ
18.	The future seems vague and uncertain to me.	Ⓣ Ⓕ
19.	I can look forward to more good times than bad times.	Ⓣ Ⓕ
20.	There's no use in really trying to get anything I want because I probably won't get it.	Ⓣ Ⓕ

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DAS – 24 (Power et al, 1994)

This scale lists different attitudes or beliefs which people sometimes hold. Please read each statement carefully and decide how much you **agree or disagree** with what it says.
For each of the attitudes please indicate your answer by placing a tick under the column that **best describes how you think.** Be sure to choose only one answer for each attitude. But please note that because people are different, there is no right or wrong answer to these statements.
To decide whether a given answer is typical of your way of looking at things, simply keep in mind what you are like **most of the time.**

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
f I fail partly, it is as as being a complete ure.							
f others dislike you, cannot be happy.							
should be happy all time.							
eople will probably ak less of me if I make istake.							
Ay happiness depends e on other people n it does on me.							
should always have plete control over my ings.							
Ay life is wasted ss I am a success.							
What other people k about me is very ortant							
ought to be able to e my problems kly and without a at deal of effort.							
If I don't set the est standards for self, I am likely to end a second rate person.							
I am nothing if a son I love doesn't love							
A person should be to control what pens to him.							

DAS – 24 (Contd)

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
If I am to be a ·thwhile person, I st be truly standing in at least major aspect.							
If you don't have er people to lean on, are bound to be sad.							
It is possible for a son to be scolded and get upset.							
I must be a useful, ductive, creative son or life has no pose.							
I can find happiness hout being loved by ther person.							
A person should do l at everything he lertakes.							
If I do not do well all time, people will not pect me.							
I do not need the proval of other people rder to be happy.							
If I try hard enough, uld be able to excel at rything I attempt.							
People who have d ideas are more ·thy than those who not.							
A person doesn't d to be well liked in er to be happy.							
Whenever I take a nce or risk I am only king for trouble.							

ATQ

AME _____ Date _____

sted below are a variety of thoughts that pop into people's heads. Please read each thought nd indicate how frequently, if at all, the thoughts occurred to you over the last two weeks. ease read each item carefully and circle the appropriate answers on the answer sheet in the llowing fashion.

= not at all 2 = sometimes 3 = moderately often 4 = often 5 = all the time

	Items	Response				
1	I feel like I'm up against the world	1	2	3	4	5
2	I'm no good	1	2	3	4	5
3	Why can't I ever succeed?	1	2	3	4	5
4	No-one understands me	1	2	3	4	5
5	I've let people down	1	2	3	4	5
6	I don't think I can go on	1	2	3	4	5
7	I wish I were a better person	1	2	3	4	5
8	I'm so weak	1	2	3	4	5
9	My life's not going the way I want it to	1	2	3	4	5
10	I'm so disappointed in myself	1	2	3	4	5
11	Nothing feels good any more	1	2	3	4	5
12	I can't stand this any more	1	2	3	4	5
13	I can't get started	1	2	3	4	5
14	What's wrong with me?	1	2	3	4	5
15	I wish I were somebody else	1	2	3	4	5
16	I can't get things together	1	2	3	4	5
17	I hate myself	1	2	3	4	5
18	I'm worthless	1	2	3	4	5
19	I wish I could just disappear	1	2	3	4	5
20	What's the matter with me?	1	2	3	4	5
21	I'm a loser	1	2	3	4	5
22	My life is a mess	1	2	3	4	5
23	I'm a failure	1	2	3	4	5
24	I'll never make it	1	2	3	4	5
25	I feel so helpless	1	2	3	4	5
26	Something has to change	1	2	3	4	5
27	There must be something wrong with me	1	2	3	4	5
28	My future is bleak	1	2	3	4	5
29	It's just not worth it	1	2	3	4	5
30	I can't finish anything	1	2	3	4	5

Automatic Thoughts Questionnaire

Scoring: add up the scores

Typical depressed group mean = 82
Typical control group mean = 42

Reference:

Hollon, S.D. and Kendall, P.C. (1980) Cognitive Self Statements in Depression: Development of Automatic Thoughts Questionnaire. *Cognitive Therapy and Research*, 4, 383-395.

PENNSYLVANIA STATE WORRY INVENTORY

Directions: **A number of statements which people have used to describe themselves are given below. Read each statement and then circle the number below the statement to describe how you generally feel. There are no right or wrong answers. Do not spend too much time on any statement but give the answer which seems to describe how you generally feel.**

1. **If I don't have enough time to do everything, I don't worry about it.**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

2. **My worries overwhelm me.**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

3. **I don't tend to worry about things**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

4. **Many situations make me worry**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

5. **I know I shouldn't worry about things but I just can't help it**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

6. **When I am under pressure I worry a lot**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

7. **I am always worrying about something**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

8. **I find it easy to dismiss worrisome thoughts**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

PENNSYLVANIA STATE WORRY INVENTORY

9. As soon as I finish one task, I start to worry about everything else I have to do

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

10. I never worry about anything

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

11. When there is nothing more I can do about a concern, I don't worry about it anymore

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

12. I've been a worrier all my life

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

13. I notice that I have been worrying about things

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

14. Once I start worrying, I can't stop

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

15. I worry all the time

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

16. I worry about projects until they are all done

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

WHOQOL-BREF

Field Trial Version
December 1996

PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANISATION
GENEVA

ABOUT YOU

fore you begin we would like to ask you to answer a few general questions about yourself by circling the rrect answer or by filling in the space provided

hat is your gender? Male Female

hat is your date of birth? _____ / _____ / _____
Day Month Year

hat is the highest education you received? None at all
Primary school
Secondary school
Tertiary

hat is your marital status? Single Separated
Married Divorced
Living as married Widowed

e you currently ill? Yes No

something is wrong with your health what do you think it is?
_____ illness/problem

struction
iis questionnaire asks how you feel about your quality of life, health, or other areas of your life. Please swer all the questions.
you are unsure about which response to give to a question, please choose the one that appears most propriate. This can often be your first response.

ease keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in e last two weeks. For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

ou should circle the number that best fits how much support you got from others over the last two weeks. So u would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	(4)	5

ou would circle number 1 if you did not get any of the support that you needed from others in the last o weeks. Please read each question assessment feelings and circle the number of the scale for each estion that gives the best answer for you

		Very poor	Poor	Neither poor nor good	Good	Very good
G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
34)	How satisfied are you with your health?	1	2	3	4	5

Le following questions ask about how much you have experienced certain things in the last two weeks

		Not at all	A little	A moderate amount	Very much	An extreme amount
.4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
.1)	How much do you enjoy life?	1	2	3	4	5
4.2	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
.3)	How well are you able to concentrate?	1	2	3	4	5
6.1)	How safe do you feel in your daily life?	1	2	3	4	5
2.1)	How healthy is your physical environment?	1	2	3	4	5

-e following questions ask about how completely you experience or were able to do certain things in the -t two weeks

		Not at all	A little	Moderately	Mostly	Completely
.1)	Do you have enough energy for everyday life?	1	2	3	4	5
.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
8.1)	Have you enough money to meet your needs?	1	2	3	4	5
0.1)	How available to you is the information that you need in your day to day life?	1	2	3	4	5
1.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
.1)	How well are you able to get around?	1	2	3	4	5

-e following questions ask you to say how good or satisfied you have felt about various aspects of your : over the last two weeks

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
.3)	How satisfied are you with your sleep?	1	2	3	4	5
).3)	How satisfied are you with your ability to perform your daily living activities??	1	2	3	4	5
2.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
.3)	How satisfied are you with yourself?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
3.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
5.3)	How satisfied are you with your sex life?	1	2	3	4	5
4.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
7.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
9.3)	How satisfied are you with your access to health services?	1	2	3	4	5
3.3)	How satisfied are you with your transport?	1	2	3	4	5

ıe following question refers to how often you have felt or experienced certain things in the last two ·eks

		Never	Seldom	Quite often	Very often	Always
.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

d someone help you to fill out this form? .....

ow long did it take to fill this form out? .....

ı you have any comments about the questionnaire? .....

.....

.....

THANK YOU FOR YOUR HELP

· office use only _____

	Equations for computing domain scores	Raw score	Transformed score*
nain 1	**(6-Q3) + (6-Q4) + Q10) + Q15 + Q16 + Q17 + Q18** ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	
nain 2	**Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)** ☐ ☐ ☐ ☐ ☐ ☐	=	
nain 3	**Q20 + Q21 + Q22** ☐ ☐ ☐	=	
nain 4	**Q8 + Q9 + Q12 + Q13 +Q14 + Q23 +Q24 +Q25** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	

lease see table on page 9 of the manual for converting raw scores to transformed score

CLIENT SERVICE RECEIPT INVENTORY

LATE LIFE DEPRESSION RESEARCH TRIAL

CSO GRANT NO:K/OPR/2/2/D367

1. CLIENT DETAILS

1.1 Client's Name _____ Identification Number ☐☐☐☐

1.2 Interview Baseline =1, End of treatment =2, 6m Follow-up =4 ☐

1.3 Interview date ☐☐/☐☐/☐☐ (d d m m y y)

1.4 Client's age ☐☐ Primary Carers age ☐☐

1.5 Client's sex Female = 1, Male = 2 ☐ Carers sex Female = 1, Male = 2 ☐

1.6 Primary Carers relationship to client ☐☐

1 Spouse
2 Son/Daughter
3 Son/Daughter-in-law
4 Sibling
5 Other relative
6 Friend
7 Neighbour
8 Other (please specify)
9 Not Applicable

1.7 Marital status ☐☐

1 Single/unmarried
2 Married/living with partner
3 Separated
4 Divorced
5 Widow/widower
6 Not known

1.8 What is/was your occupation?
If interviewee is female determine husband's occupation

_____

1.9 In which of the following categories of accommodation is the client currently resident? ☐

1 Owner-occupied house/flat
2 Privately rented house/flat
3 House/flat rented from housing association/local authority
4 Residential home
5 Nursing home
6 Dual registered home
7 Sheltered housing
8 Other (please specify)

1.9a How many adults live in client's household? ☐

Number of rooms ☐☐

1.9b Do you own a car? YES/NO

2. *INFORMAL CARE*

In the last 6 months, have you received help from **friends or relatives** on any of the following tasks, as a consequence of emotional problems?

Type of help	*Circle*	*Helper's relationship to you (see key below)**	*Average number of hours help per week*	*Average cost per week (£)*
Personal Support *(e.g. company)*	No Yes			
Help in/ around the house *(e.g., cooking, cleaning etc.)*	No Yes			
Help outside the home *(e.g., shopping, transport etc.)*	No Yes			
Other _____	No Yes			

* Key: 1 = Mother; 2 = Father; 3 = Brother/ Sister; 4 = Other Relative; 5 = Friend; 6 = Other (please specify)

3. *SERVICE RECEIPT*

3.1 Please list any use of the following **hospital services** over the last 6 months
(Note : please enter '0' if service has not been used)

Service	**Name of ward, clinic or centre**	**Reason for using service**	**Unit of measure-ment**	**Number of units received (over the last 6 months)**
Assessment/rehab. Ward			Inpatient day	
Continuing care/respite ward			Inpatient day	
Medical ward			Inpatient day	
Other hospital ward (e.g. psychiatric)			Inpatient day	
Outpatient visit			Appointment	
Day treatment			Appointment	
Day hospital			Day attendance	
Other:				

3.2 Please list any use of the following **day services** over the last 6 months
(Note: please enter '0' if service has not been used)

Service	**Name of centre/service**	**Unit of measure-ment**	**Number of units received per week**	**Total number of units received over the last 6 months**
Day care – Local Authority		Days		
Day care - vol.		Days		
Day care – NHS (not hosp.)		Days		
Lunch club		Visits		
Social club		Visits		
Other		State:		

3.3 How does the client travel to day care?

1 Private car ☐
2 Taxi
3 Transport arranged by day service
4 Other (please specify) _____

3.4 Please list any use the client has made of **community-based services** over the last
6 months
(Note: please enter '0' if service has not been used)

Service*	**Domiciliary visit/office visit *(circle one)***	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of non-enhanced hours received (over the last 6 months)**	**Total number of enhanced hours received (over the last 6 months)**
Care manager	DV OV					
Social worker	DV OV					
Home care worker	DV OV					
Care attendant	DV OV					
Sitting scheme	DV OV					
Carer's support worker	DV OV					
District nurse	DV OV					
Occupational therapist	DV OV					

3.4 (continued)

Service*	**Domiciliary visit/office visit *(circle one)***	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of units received (over the last 6 months)**
Meals on wheels	DV OV				
Laundry service	DV OV				
General practitioner	DV OV				
Community psychiatrist	DV OV				
Geriatrician	DV OV				
Psychologist	DV OV				
CPN	DV OV				
Health visitor	DV OV				
Occupational therapist	DV OV				
Physiotherapist	DV OV				
Chiropodist	DV OV				
Other: e.g. complementary therapies, counsellor, aroma-therapist, dentist					
1.	DV OV				
2.	DV OV				
3.	DV OV				
4.	DV OV				

3.5 Please list any use of **privately arranged services** paid for by the client over the last 6 months
(e.g. gardening, cleaning)

Specify service	**Unit of measurement**	**Number of units received (over the last 6 months)**	**Total cost)**

4. *INCOME SOURCE*

4.1 Does the client receive any of the following benefits? *(Please tick all boxes that apply)*

Income support, income-based jobseeker's allowance	☐
Housing benefit	☐
Council-tax benefit	☐
Incapacity benefit	☐
Severe disablement allowance	☐
Invalid care allowance	☐
Attendance allowance	☐
Disability living allowance	☐
Retirement pension	☐
Other _____	☐
Total benefits received	☐☐

4.2 What is your main income source?

1 Salary/Wage
2 State benefits
3 Pension – occupation/state
4 Family support (eg from spouse)
5 Other ☐

5. Please list below use of any drugs taken for <u>emotional problems</u> over the <u>last six months</u>

Name of drug	***Dosage (if known)***	***Dose frequency (e.g. daily)***	***For how long have you taken this drug?***
1.	*mg*		
2.	*mg*		
3.	*mg*		
4.	*mg*		
5.	*mg*		

THANK YOU

LATE LIFE DEPRESSION PROJECT

ASSESSMENT AT 3 MONTHS FOLLOW-UP

NAME:	DATE:

1. **BDI II** – patient self report ☐
2. **HRS-D** – completed by research assistant ☐
3. **GDS** – patient self report ☐
4. **LIFE-II** – administered by research assistant ☐
5. **BHS** – patient self report ☐
6. **DAS** – patient self report ☐
7. **ATQ** – patient self report ☐
8. **PSWI** – patient self report ☐
9. **QOL-BRF** – patient self report ☐
10. **CSRI** – completed by patient ☐
11. **DATE OF NEXT INTERVIEW** – give patient date of 6 month follow-up assessment ☐

BDI-II

Date:

: _____ Marital Status: _____ Age: _____ Sex: _____

ɔation: _____ Education: _____

ıctions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and ick out the **one statement** in each group that best describes the way you have been feeling during the **past two , including today**. Circle the number beside the statement you have picked. If several statements in the group o apply equally well, circle the highest number for that group. Be sure that you do not choose more than one ent for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

;adness

I do not feel sad.

I feel sad much of the time.

I am sad all the time.

I am so sad or unhappy that I can't stand it.

-essimism

I am not discouraged about my future.

I feel more discouraged about my future than I used to be.

I do not expect things to work out for me.

I feel my future is hopeless and will only get worse.

ast Failure

I do not feel like a failure.

I have failed more than I should have.

As I look back, I see a lot of failures.

I feel I am a total failure as a person.

oss of Pleasure

I get as much pleasure as I ever did from the things I enjoy.

I don't enjoy things as much as I used to.

I get very little pleasure from the things I used to enjoy.

I can't get any pleasure from the things I used to enjoy.

ıilty Feelings

I don't feel particularly guilty.

I feel guilty over many things I have done or should have done.

I feel quite guilty most of the time.

I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

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gitation

I am no more restless or wound up than usual.

I feel more restless or wound up than usual.

I am so restless or agitated that it's hard to stay still.

I am so restless or agitated that I have to keep moving or doing something.

oss of Interest

I have not lost interest in other people or activities.

I am less interested in other people or things than before.

I have lost most of my interest in other people or things.

It's hard to get interested in anything.

ıdecisiveness

I make decisions about as well as ever.

I find it more difficult to make decisions than usual.

I have much greater difficulty in making decisions than I used to.

I have trouble making any decisions.

Vorthlessness

I do not feel I am worthless.

I don't consider myself as worthwhile and useful as I used to.

I feel more worthless as compared to other people.

I feel utterly worthless.

oss of Energy

I have as much energy as ever.

I have less energy than I used to have.

I don't have enough energy to do very much.

I don't have enough energy to do anything.

hanges in Sleeping Pattern

I have not experienced any change in my sleeping pattern.

I sleep somewhat more than usual.

I sleep somewhat less than usual.

I sleep a lot more than usual.

I sleep a lot less than usual.

I sleep most of the day.

I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

This form is printed with both blue and black ink. If your
s not appear this way, it has been photocopied in
of copyright laws.

Hamilton Depression Scale – 17 (HAM-D)

Client Name: _____ Date: _____

***Instructions*: Circle one number per item. Score all items.**

1. **Depressed Mood (sad, blue, gloomy, weepy, pessimistic, helpless, hopeless, worthless)**
   - 0 Not depressed
   - 1 Feeling states elicited only on questioning
   - 2 Occasional weeping or spontaneously reports feeling states.
   - 3 Frequent weeping. Obvious behavioural evidence in facies, posture, voice. Speaks mostly about feeling states.
   - 4 Exhibits virtually only these feeling states verbally and nonverbally. May have "gone beyond weeping".

2. **Guilt feelings and delusions**
   - 0 Absent
   - 1 Self-reproach, feels he/she has let people down
   - 2 Expresses guilt over past errors
   - 3 Present illness is deserved punishment. Ruminations over past errors and sins.
   - 4 Severe self-reproach. Guilty delusions e.g. is making other people ill. Deserves to die. May have accusatory or denouncing auditory or visual hallucinations.

3. **Suicide**
   - 0 Absent
   - 1 Feels life is empty, not worth living
   - 2 Recurrent thoughts or wishes about death of self
   - 3 Active suicidal thoughts, threats, gestures
   - 4 Serious suicide attempt

4. **Initial Insomnia (as part of present illness)**
   - 0 Absent
   - 1 Mild, infrequent, less than ½ hour
   - 2 Obvious and severe, more than ½ hour usually

5. **Middle Insomnia**
   - 0 Absent (Rate 1 if hypnotic is being used)
   - 1 Complains of feeling restless and disturbed during night
   - 2 Wakes during the night: any reading or smoking in bed or getting out of bed except to void.

6. **Delayed Insomnia**
   - 0 Absent
   - 1 Wakes earlier than usual
   - 2 Wakes 1 – 3 hours before usual, unable to sleep again.

7. **Work and Activities (Apathy: loss of interest in work, hobbies, social life. Anhedonia: unable to feel pleasure)**
   - 0 No disturbance
   - 1 Feels incapable, listless, less efficient. (Rate fatigue, loss of energy under item 13)
   - 2 Has to push self to work or play. No active interests, gets little satisfaction, feels listless, indecisive.
   - 3 Clearly decreased efficiency. Spends less time at usual work.
   - 4 Stopped work because of present illness. Doesn't shave, bathe etc. Works only with urging.

8. **Retardation (psychomotor slowing of thought, speech, and movement)**
   - 0 Absent
   - 1 Slight flattened affect, fixed facial expression
   - 2 Monotonous voice, delayed answering, sits motionless
   - 3 Interview difficult and prolonged. Moves slowly.
   - 4 Depressive stupor. Interview impossible.

Hamilton Depression Scale – 17 (HAM-D)

9. Agitation (may co-exist mildly with retardation)

0 None
1 Fidgety
2 Playing with hands or hair, picking at hands or clothes
3 Moving about, can't sit still
4 Hand wringing, nail biting, hair pulling, biting of lips.

10. Psychic Anxiety (as part of present illness, NOT part of previous disposition. Includes feeling tense, irritable, apprehensive, fearful, phobic or panic attacks).

0 Absent
1 Minimal distress, admitted only on direct questioning.
2 Spontaneously expresses discomfort; worries over trivia.
3 Obviously apprehensive in face of speech.
4 Severely anxious, panicky.

11. **Somatic Anxiety (physiological concomitants of anxiety such as: fainting, tinnitus, blurred vision, headache, tremor, sweating, flushing, hyperventilation, palpitations, indigestion, belching, diarrhoea, urinary frequency**).

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

12. Somatic Symptoms Gastrointestinal

0 Normal appetite
1 East spontaneously but without relish
2 Marked reduction of appetite and food intake. Eats only with urging. Requests or requires laxatives.

13. Somatic energy

0 Normal
1 Occasional mild fatigue, easy tiring, aching.
2 Obviously low in energy, tired all the time: frequent backaches, headaches, heavy feelings in limbs

14. Genital Symptoms (rate change in libido, impotence, menstrual disturbances)

0 Absent
1 Mild
2 Severe

15. Hypochondriasis

0 Absent
1 Self-absorbed about bodily functions and physical symptoms
2 Preoccupied with health
3 Frequent complaints, requests for help etc.
4 Morbid convictions of organic disease e.g. brain tumour, cancer, or delusion e.g. worms eating head getting inside, bowels blocked, terrible odour

16. Weight loss (when rated by history, according to subject)

0 No weight loss
1 Probable weight loss
2 Definite weight loss

17. Loss of Insight

0 Acknowledges being depressed
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

LATE LIFE DEPRESSION PROJECT

G. D. SCREENING SCALE (YESAVAGE)
(SHORT FORM)

NAME:	DATE:

Please answer all the following questions by ringing either 'YES' or 'NO'

1. Are you basically satisfied with your life?	**YES/ NO**
2. Have you dropped many of your activities and interests?	**YES /NO**
3. Do you feel that your life is empty?	**YES//NO**
4. Do you often get bored?	**YES/NO**
5. Are you in good spirits most of the time?	**YES/ NO**
6. Are you afraid that something bad is going to happen to you?	**YES/NO**
7. Do you feel happy most of the time?	**YES/NO**
8. Do you often feel helpless?	**YES/NO**
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES/NO**
10. Do you feel you have more problems with memory than most?	**YES/NO**
11. Do you think it is wonderful to be alive now?	**YES/NO**
12. Do you feel pretty worthless the way you are now?	**YES/NO**
13. Do you feel full of energy?	**YES/NO**
14. Do you feel that your situation is hopeless?	**YES/NO**
15. Do you think that most people are better off than you?	**YES/NO**

BHS

Date:_____

ıme:_____ Marital Status:_____ Age:_____ Sex:_____

cupation:_____ Education:_____

is questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement :cribes your attitude for the **past week including today,** darken the circle with a 'T' indicating TRUE in the umn next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' icating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	Ⓣ Ⓕ
2.	I might as well give up because there is nothing I can do about making things better for myself.	Ⓣ Ⓕ
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	Ⓣ Ⓕ
4.	I can't imagine what my life would be like in ten years.	Ⓣ Ⓕ
5.	I have enough time to accomplish the things I want to do.	Ⓣ Ⓕ
6.	In the future, I expect to succeed in what concerns me most.	Ⓣ Ⓕ
7.	My future seems dark to me.	Ⓣ Ⓕ
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	Ⓣ Ⓕ
9.	I just can't get the breaks, and there's no reason I will in the future.	Ⓣ Ⓕ
10.	My past experiences have prepared me well for the future.	Ⓣ Ⓕ
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	Ⓣ Ⓕ
12.	I don't expect to get what I really want.	Ⓣ Ⓕ
13.	When I look ahead to the future, I expect that I will be happier than I am now.	Ⓣ Ⓕ
14.	Things just don't work out the way I want them to.	Ⓣ Ⓕ
15.	I have great faith in the future.	Ⓣ Ⓕ
16.	I never get what I want, so it's foolish to want anything.	Ⓣ Ⓕ
17.	It's very unlikely that I will get any real satisfaction in the future.	Ⓣ Ⓕ
18.	The future seems vague and uncertain to me.	Ⓣ Ⓕ
19.	I can look forward to more good times than bad times.	Ⓣ Ⓕ
20.	There's no use in really trying to get anything I want because I probably won't get it.	Ⓣ Ⓕ

THE PSYCHOLOGICAL CORPORATION
HARCOURT BRACE JOVANOVICH, INC.

DAS – 24 (Power et al, 1994)

This scale lists different attitudes or beliefs which people sometimes hold. Please read each statement carefully and decide how much you **agree or disagree** with what it says.
For each of the attitudes please indicate your answer by placing a tick under the column that **best describes how you think.** Be sure to choose only one answer for each attitude. But please note that because people are different, there is no right or wrong answer to these statements.
To decide whether a given answer is typical of your way of looking at things, simply keep in mind what you are like **most of the time.**

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
I fail partly, it is as as being a complete ure.							
others dislike you, cannot be happy.							
should be happy all ime.							
eople will probably k less of me if I make stake.							
y happiness depends e on other people it does on me.							
should always have plete control over my ngs.							
y life is wasted ss I am a success.							
hat other people k about me is very ortant							
ought to be able to e my problems kly and without a t deal of effort.							
f I don't set the est standards for elf, I am likely to end second rate person.							
am nothing if a on I love doesn't love							
A person should be to control what ens to him.							

DAS – 24 (Contd)

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
If I am to be a thwhile person, I st be truly standing in at least major aspect.							
If you don't have er people to lean on, are bound to be sad.							
It is possible for a son to be scolded and get upset.							
I must be a useful, ductive, creative son or life has no pose.							
I can find happiness out being loved by ther person.							
A person should do at everything he ertakes.							
If I do not do well all time, people will not ect me.							
I do not need the roval of other people rder to be happy.							
If I try hard enough, uld be able to excel at ything I attempt.							
People who have l ideas are more thy than those who ot.							
A person doesn't l to be well liked in er to be happy.							
Whenever I take a ace or risk I am only ing for trouble.							

ATQ

AME _____ Date _____

sted below are a variety of thoughts that pop into people's heads. Please read each thought d indicate how frequently, if at all, the thoughts occurred to you over the last two weeks. ease read each item carefully and circle the appropriate answers on the answer sheet in the llowing fashion.

= not at all 2 = sometimes 3 = moderately often 4 = often 5 = all the time

	Items	Response				
	I feel like I'm up against the world	1	2	3	4	5
.	I'm no good	1	2	3	4	5
	Why can't I ever succeed?	1	2	3	4	5
	No-one understands me	1	2	3	4	5
	I've let people down	1	2	3	4	5
	I don't think I can go on	1	2	3	4	5
'	I wish I were a better person	1	2	3	4	5
	I'm so weak	1	2	3	4	5
`	My life's not going the way I want it to	1	2	3	4	5
0	I'm so disappointed in myself	1	2	3	4	5
1	Nothing feels good any more	1	2	3	4	5
2	I can't stand this any more	1	2	3	4	5
3	I can't get started	1	2	3	4	5
4	What's wrong with me?	1	2	3	4	5
5	I wish I were somebody else	1	2	3	4	5
6	I can't get things together	1	2	3	4	5
7	I hate myself	1	2	3	4	5
8	I'm worthless	1	2	3	4	5
9	I wish I could just disappear	1	2	3	4	5
0	What's the matter with me?	1	2	3	4	5
1	I'm a loser	1	2	3	4	5
2	My life is a mess	1	2	3	4	5
3	I'm a failure	1	2	3	4	5
4	I'll never make it	1	2	3	4	5
5	I feel so helpless	1	2	3	4	5
6	Something has to change	1	2	3	4	5
7	There must be something wrong with me	1	2	3	4	5
8	My future is bleak	1	2	3	4	5
9	It's just not worth it	1	2	3	4	5
0	I can't finish anything	1	2	3	4	5

Automatic Thoughts Questionnaire

Scoring: add up the scores

Typical depressed group mean = 82
Typical control group mean = 42

Reference:

Hollon, S.D. and Kendall, P.C. (1980) Cognitive Self Statements in Depression: Development of Automatic Thoughts Questionnaire. *Cognitive Therapy and Research*, 4, 383-395.

PENNSYLVANIA STATE WORRY INVENTORY

Directions: **A number of statements which people have used to describe themselves are given below. Read each statement and then circle the number below the statement to describe how you generally feel. There are no right or wrong answers. Do not spend too much time on any statement but give the answer which seems to describe how you generally feel.**

1. **If I don't have enough time to do everything, I don't worry about it.**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

2. **My worries overwhelm me.**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

3. **I don't tend to worry about things**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

4. **Many situations make me worry**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

5. **I know I shouldn't worry about things but I just can't help it**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

6. **When I am under pressure I worry a lot**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

7. **I am always worrying about something**

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

8. **I find it easy to dismiss worrisome thoughts**

1----------2----------3---------4----------5
not at all typical of me **very typical of me**

PENNSYLVANIA STATE WORRY INVENTORY

9. As soon as I finish one task, I start to worry about everything else I have to do

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

10. I never worry about anything

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

11. When there is nothing more I can do about a concern, I don't worry about it anymore

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

12. I've been a worrier all my life

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

13. I notice that I have been worrying about things

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

14. Once I start worrying, I can't stop

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

15. I worry all the time

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

16. I worry about projects until they are all done

1----------2----------3----------4----------5
not at all typical of me **very typical of me**

WHOQOL-BREF

Field Trial Version
December 1996

PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANISATION
GENEVA

ABOUT YOU

fore you begin we would like to ask you to answer a few general questions about yourself by circling the rect answer or by filling in the space provided

at is your gender? Male Female

at is your date of birth? _____ / _____ / _____
Day Month Year

at is the highest education you received? None at all
Primary school
Secondary school
Tertiary

at is your marital status? Single Separated
Married Divorced
Living as married Widowed

you currently ill? Yes No

omething is wrong with your health what do you think it is?
_____ illness/problem

truction
is questionnaire asks how you feel about your quality of life, health, or other areas of your life. Please wer all the questions.
ou are unsure about which response to give to a question, please choose the one that appears most propriate. This can often be your first response.

ase keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in last two weeks. For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

u should circle the number that best fits how much support you got from others over the last two weeks. So u would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	(4)	5

u would circle number 1 if you did not get any of the support that you needed from others in the last o weeks. Please read each question assessment feelings and circle the number of the scale for each estion that gives the best answer for you

		Very poor	Poor	Neither poor nor good	Good	Very good
1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
4)	How satisfied are you with your health?	1	2	3	4	5

following questions ask about how much you have experienced certain things in the last two weeks

		Not at all	A little	A moderate amount	Very much	An extreme amount
4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
)	How much do you enjoy life?	1	2	3	4	5
2	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
)	How well are you able to concentrate?	1	2	3	4	5
1)	How safe do you feel in your daily life?	1	2	3	4	5
1)	How healthy is your physical environment?	1	2	3	4	5

following questions ask about how completely you experience or were able to do certain things in the wo weeks

		Not at all	A little	Moderately	Mostly	Completely
	Do you have enough energy for everyday life?	1	2	3	4	5
	Are you able to accept your bodily appearance?	1	2	3	4	5
)	Have you enough money to meet your needs?	1	2	3	4	5
)	How available to you is the information that you need in your day to day life?	1	2	3	4	5
)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
	How well are you able to get around?	1	2	3	4	5

following questions ask you to say how good or satisfied you have felt about various aspects of your ver the last two weeks

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
	How satisfied are you with your sleep?	1	2	3	4	5
	How satisfied are you with your ability to perform your daily living activities??	1	2	3	4	5
	How satisfied are you with your capacity for work?	1	2	3	4	5
	How satisfied are you with yourself?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
3.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
5.3)	How satisfied are you with your sex life?	1	2	3	4	5
4.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
7.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
9.3)	How satisfied are you with your access to health services?	1	2	3	4	5
3.3)	How satisfied are you with your transport?	1	2	3	4	5

e following question refers to how often you have felt or experienced certain things in the last two eks

		Never	Seldom	Quite often	Very often	Always
.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

d someone help you to fill out this form? .....

w long did it take to fill this form out? .....

you have any comments about the questionnaire? .....

.....

.....

THANK YOU FOR YOUR HELP

office use only _____

	Equations for computing domain scores	Raw score	Transformed score*
ain 1	**(6-Q3) + (6-Q4) + Q10) + Q15 + Q16 + Q17 + Q18** ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	
ain 2	**Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)** ☐ ☐ ☐ ☐ ☐ ☐	=	
ain 3	**Q20 + Q21 + Q22** ☐ ☐ ☐	=	
ain 4	**Q8 + Q9 + Q12 + Q13 +Q14 + Q23 +Q24 +Q25** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	

ease see table on page 9 of the manual for converting raw scores to transformed score

CLIENT SERVICE RECEIPT INVENTORY

LATE LIFE DEPRESSION RESEARCH TRIAL

CSO GRANT NO:K/OPR/2/2/D367

1. CLIENT DETAILS

1.1 Client's Name _____ Identification Number ☐☐☐☐

1.2 Interview Baseline =1, End of treatment =2, 6m Follow-up =4 ☐

1.3 Interview date ☐☐/☐☐/☐☐ (d d m m y y)

1.4 Client's age ☐☐ Primary Carers age ☐☐

1.5 Client's sex Female = 1, Male = 2 ☐ Carers sex Female = 1, Male = 2 ☐

1.6 Primary Carers relationship to client ☐☐

1 Spouse
2 Son/Daughter
3 Son/Daughter-in-law
4 Sibling
5 Other relative
6 Friend
7 Neighbour
8 Other (please specify)
9 Not Applicable

1.7 Marital status ☐☐

1 Single/unmarried
2 Married/living with partner
3 Separated
4 Divorced
5 Widow/widower
6 Not known

1.8 What is/was your occupation?
If interviewee is female determine husband's occupation

_____

1.9 In which of the following categories of accommodation is the client currently resident? ☐

1 Owner-occupied house/flat
2 Privately rented house/flat
3 House/flat rented from housing association/local authority
4 Residential home
5 Nursing home
6 Dual registered home
7 Sheltered housing
8 Other (please specify)

1.9a How many adults live in client's household? ☐

Number of rooms ☐☐

1.9b Do you own a car? YES/NO

2. *INFORMAL CARE*

In the last 6 months, have you received help from **friends or relatives** on any of the following tasks, as a consequence of emotional problems?

Type of help	*Circle*	*Helper's relationship to you (see key below)**	*Average number of hours help per week*	*Average cost per week (£)*
Personal Support *(e.g. company)*	No Yes			
Help in/ around the house *(e.g., cooking, cleaning etc.)*	No Yes			
Help outside the home *(e.g., shopping, transport etc.)*	No Yes			
Other _____	No Yes			

* Key: 1 = Mother; 2 = Father; 3 = Brother/ Sister; 4 = Other Relative; 5 = Friend; 6 = Other (please specify)

3. *SERVICE RECEIPT*

3.1 Please list any use of the following **hospital services** over the last 6 months
(Note: please enter '0' if service has not been used)

Service	**Name of ward, clinic or centre**	**Reason for using service**	**Unit of measure-ment**	**Number of units received (over the last 6 months)**
Assessment/rehab. Ward			Inpatient day	
Continuing care/respite ward			Inpatient day	
Medical ward			Inpatient day	
Other hospital ward (e.g. psychiatric)			Inpatient day	
Outpatient visit			Appointment	
Day treatment			Appointment	
Day hospital			Day attendance	
Other:				

3.2 Please list any use of the following **day services** over the last 6 months
(Note: please enter '0' if service has not been used)

Service	**Name of centre/service**	**Unit of measure-ment**	**Number of units received per week**	**Total number of units received over the last 6 months**
Day care – Local Authority		Days		
Day care - vol.		Days		
Day care – NHS (not hosp.)		Days		
Lunch club		Visits		
Social club		Visits		
Other		State:		

3.3 How does the client travel to day care?

1 Private car ☐
2 Taxi
3 Transport arranged by day service
4 Other (please specify) _____

3.4 Please list any use the client has made of **community-based services** over the last
6 months
(Note: please enter '0' if service has not been used)

Service*	**Domiciliary visit/office visit *(circle one)***	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of non-enhanced hours received (over the last 6 months)**	**Total number of enhanced hours received (over the last 6 months)**
Care manager	DV OV					
Social worker	DV OV					
Home care worker	DV OV					
Care attendant	DV OV					
Sitting scheme	DV OV					
Carer's support worker	DV OV					
District nurse	DV OV					
Occupational therapist	DV OV					

3.4 (continued)

Service*	**Domiciliary visit/office visit** *(circle one)*	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of units received (over the last 6 months)**
Meals on wheels	DV OV				
Laundry service	DV OV				
General practitioner	DV OV				
Community psychiatrist	DV OV				
Geriatrician	DV OV				
Psychologist	DV OV				
CPN	DV OV				
Health visitor	DV OV				
Occupational therapist	DV OV				
Physiotherapist	DV OV				
Chiropodist	DV OV				
Other: e.g. complementary therapies, counsellor, aroma-therapist, dentist					
1.	DV OV				
2.	DV OV				
3.	DV OV				
4.	DV OV				

3.5 Please list any use of **privately arranged services** paid for by the client over the last 6 months
(e.g. gardening, cleaning)

Specify service	**Unit of measurement**	**Number of units received (over the last 6 months)**	**Total cost)**

4. *INCOME SOURCE*

4.1 Does the client receive any of the following benefits? *(Please tick all boxes that apply)*

- Income support, income-based jobseeker's allowance ☐
- Housing benefit ☐
- Council-tax benefit ☐
- Incapacity benefit ☐
- Severe disablement allowance ☐
- Invalid care allowance ☐
- Attendance allowance ☐
- Disability living allowance ☐
- Retirement pension ☐
- Other _____ ☐
- Total benefits received ☐☐

4.2 What is your main income source?

1 Salary/Wage
2 State benefits
3 Pension – occupation/state
4 Family support (eg from spouse)
5 Other ☐

5. Please list below use of any drugs taken for <u>emotional problems</u> over the <u>last six months</u>

Name of drug	***Dosage (if known)***	***Dose frequency (e.g. daily)***	***For how long have you taken this drug?***
1.	*mg*		
2.	*mg*		
3.	*mg*		
4.	*mg*		
5.	*mg*		

THANK YOU

MENTAL STATE ASSESSMENT

Name **Date**

ORIENTATION: Score 1 point for each correct answer to following

Time?	**Date?**	**Day?**	**Month?**	**Year?**	(____)
PM?	**Monarch?**	**Town?**	**District?**	**Country?**	(____)

REGISTRATION: Examiner names 3 objects. Score up to 3 points if, on the first attempt, the subject repeats, in order, the 3 objects. Score 2 or 1 if this is the number of objects he repeats correctly. Use further attempts and prompting to have all 3 repeated, so as to test recall later. (____)

ATTENTION & CALCULATION: Ask the subject to subtract 7 from 100, then 7 from the result – repeat this 5 times, scoring 1 point for each correct subtraction (max. score 5 points). **OR** ask the subject to spell "WORLD" backwards. (____)

RECALL: Ask for the 3 objects named in the registration test scoring 1 point for each. (____)

LANGUAGE:

Score 1 point for each of two objects (pen & watch) correctly named. (____)

Score 1 point for the correct repetition of this phrase (____)
"No ifs, ands or buts"

Score 3 if a three-stage command is correctly executed or 1 for each stage. **"With the index finger of your right hand touch the tip of your nose and then your left ear"** (____)

On a blank piece of paper write **"CLOSE YOUR EYES"**. Ask the subject to obey. Score 1 point. (____)

Ask the subject to write one short sentence with a ***subject*** and a ***verb.*** Score 1 point. (____)

CONSTRUCTION & SPATIAL SENSE: Construct a pair of intersecting pentagons each side one inch long (see below). Score 1 point if this is correctly copied. (____)

TOTAL SCORE (maximum 30) (____)

LATE LIFE DEPRESSION PROJECT

ASSESSMENT AT 6 MONTHS FOLLOW-UP

NAME:	DATE:

1. **BDI II** – patient self report ☐
2. **HRS-D** – completed by research assistant ☐
3. **GDS** – patient self report ☐
4. **LIFE-II** – administered by research assistant ☐
5. **BHS** – patient self report ☐
6. **DAS** – patient self report ☐
7. **ATQ** – patient self report ☐
8. **PSWI** – patient self report ☐
9. **QOL-BRF** – patient self report ☐
10. **CSRI** – completed by patient ☐
11. **MMSE –** administered by research assistant ☐

BDI-II

Date:

e: _____ Marital Status: _____ Age: _____ Sex: _____

pation: _____ Education: _____

uctions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and pick out the **one statement** in each group that best describes the way you have been feeling during the **past two s, including today**. Circle the number beside the statement you have picked. If several statements in the group to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one nent for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

Sadness

I do not feel sad.

I feel sad much of the time.

I am sad all the time.

I am so sad or unhappy that I can't stand it.

Pessimism

I am not discouraged about my future.

I feel more discouraged about my future than I used to be.

I do not expect things to work out for me.

I feel my future is hopeless and will only get worse.

Past Failure

I do not feel like a failure.

I have failed more than I should have.

As I look back, I see a lot of failures.

I feel I am a total failure as a person.

Loss of Pleasure

I get as much pleasure as I ever did from the things I enjoy.

I don't enjoy things as much as I used to.

I get very little pleasure from the things I used to enjoy.

I can't get any pleasure from the things I used to enjoy.

Guilty Feelings

I don't feel particularly guilty.

I feel guilty over many things I have done or should have done.

I feel quite guilty most of the time.

I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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Agitation

I am no more restless or wound up than usual.

I feel more restless or wound up than usual.

I am so restless or agitated that it's hard to stay still.

I am so restless or agitated that I have to keep moving or doing something.

Loss of Interest

I have not lost interest in other people or activities.

I am less interested in other people or things than before.

I have lost most of my interest in other people or things.

It's hard to get interested in anything.

Indecisiveness

I make decisions about as well as ever.

I find it more difficult to make decisions than usual.

I have much greater difficulty in making decisions than I used to.

I have trouble making any decisions.

Worthlessness

I do not feel I am worthless.

I don't consider myself as worthwhile and useful as I used to.

I feel more worthless as compared to other people.

I feel utterly worthless.

Loss of Energy

I have as much energy as ever.

I have less energy than I used to have.

I don't have enough energy to do very much.

I don't have enough energy to do anything.

Changes in Sleeping Pattern

I have not experienced any change in my sleeping pattern.

---

a I sleep somewhat more than usual.

b I sleep somewhat less than usual.

---

a I sleep a lot more than usual.

b I sleep a lot less than usual.

---

a I sleep most of the day.

b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Hamilton Depression Scale – 17 (HAM-D)

Client Name: _____ Date: _____

***Instructions*: Circle one number per item. Score all items.**

1. Depressed Mood (sad, blue, gloomy, weepy, pessimistic, helpless, hopeless, worthless)

0 Not depressed
1 Feeling states elicited only on questioning
2 Occasional weeping or spontaneously reports feeling states.
3 Frequent weeping. Obvious behavioural evidence in facies, posture, voice. Speaks mostly about feeling states.
4 Exhibits virtually only these feeling states verbally and nonverbally. May have "gone beyond weeping".

2. Guilt feelings and delusions

0 Absent
1 Self-reproach, feels he/she has let people down
2 Expresses guilt over past errors
3 Present illness is deserved punishment. Ruminations over past errors and sins.
4 Severe self-reproach. Guilty delusions e.g. is making other people ill. Deserves to die. May have accusatory or denouncing auditory or visual hallucinations.

3. Suicide

0 Absent
1 Feels life is empty, not worth living
2 Recurrent thoughts or wishes about death of self
3 Active suicidal thoughts, threats, gestures
4 Serious suicide attempt

4. Initial Insomnia (as part of present illness)

0 Absent
1 Mild, infrequent, less than ½ hour
2 Obvious and severe, more than ½ hour usually

5. Middle Insomnia

0 Absent (Rate 1 if hypnotic is being used)
1 Complains of feeling restless and disturbed during night
2 Wakes during the night: any reading or smoking in bed or getting out of bed except to void.

6. Delayed Insomnia

0 Absent
1 Wakes earlier than usual
2 Wakes 1 – 3 hours before usual, unable to sleep again.

7. Work and Activities (Apathy: loss of interest in work, hobbies, social life. Anhedonia: unable to feel pleasure)

0 No disturbance
1 Feels incapable, listless, less efficient. (Rate fatigue, loss of energy under item 13)
2 Has to push self to work or play. No active interests, gets little satisfaction, feels listless, indecisive.
3 Clearly decreased efficiency. Spends less time at usual work.
4 Stopped work because of present illness. Doesn't shave, bathe etc. Works only with urging.

8. Retardation (psychomotor slowing of thought, speech, and movement)

0 Absent
1 Slight flattened affect, fixed facial expression
2 Monotonous voice, delayed answering, sits motionless
3 Interview difficult and prolonged. Moves slowly.
4 Depressive stupor. Interview impossible.

Hamilton Depression Scale – 17 (HAM-D)

9. Agitation (may co-exist mildly with retardation)

0 None
1 Fidgety
2 Playing with hands or hair, picking at hands or clothes
3 Moving about, can't sit still
4 Hand wringing, nail biting, hair pulling, biting of lips.

10. Psychic Anxiety (as part of present illness, NOT part of previous disposition. Includes feeling tense, irritable, apprehensive, fearful, phobic or panic attacks).

0 Absent
1 Minimal distress, admitted only on direct questioning.
2 Spontaneously expresses discomfort; worries over trivia.
3 Obviously apprehensive in face of speech.
4 Severely anxious, panicky.

11. **Somatic Anxiety (physiological concomitants of anxiety such as: fainting, tinnitus, blurred vision, headache, tremor, sweating, flushing, hyperventilation, palpitations, indigestion, belching, diarrhoea, urinary frequency**).

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

12. Somatic Symptoms Gastrointestinal

0 Normal appetite
1 East spontaneously but without relish
2 Marked reduction of appetite and food intake. Eats only with urging. Requests or requires laxatives.

13. Somatic energy

0 Normal
1 Occasional mild fatigue, easy tiring, aching.
2 Obviously low in energy, tired all the time: frequent backaches, headaches, heavy feelings in limbs

14. Genital Symptoms (rate change in libido, impotence, menstrual disturbances)

0 Absent
1 Mild
2 Severe

15. Hypochondriasis

0 Absent
1 Self-absorbed about bodily functions and physical symptoms
2 Preoccupied with health
3 Frequent complaints, requests for help etc.
4 Morbid convictions of organic disease e.g. brain tumour, cancer, or delusion e.g. worms eating head getting inside, bowels blocked, terrible odour

16. Weight loss (when rated by history, according to subject)

0 No weight loss
1 Probable weight loss
2 Definite weight loss

17. Loss of Insight

0 Acknowledges being depressed
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

LATE LIFE DEPRESSION PROJECT

G. D. SCREENING SCALE (YESAVAGE)
(SHORT FORM)

NAME:	DATE:

Please answer all the following questions by ringing either 'YES' or 'NO'

1. Are you basically satisfied with your life?	**YES/ NO**
2. Have you dropped many of your activities and interests?	**YES /NO**
3. Do you feel that your life is empty?	**YES//NO**
4. Do you often get bored?	**YES/NO**
5. Are you in good spirits most of the time?	**YES/ NO**
6. Are you afraid that something bad is going to happen to you?	**YES/NO**
7. Do you feel happy most of the time?	**YES/NO**
8. Do you often feel helpless?	**YES/NO**
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES/NO**
10. Do you feel you have more problems with memory than most?	**YES/NO**
11. Do you think it is wonderful to be alive now?	**YES/NO**
12. Do you feel pretty worthless the way you are now?	**YES/NO**
13. Do you feel full of energy?	**YES/NO**
14. Do you feel that your situation is hopeless?	**YES/NO**
15. Do you think that most people are better off than you?	**YES/NO**

BHS

Date:_____

ame:_____ Marital Status:_____ Age:_____ Sex:_____

ccupation:_____ Education:_____

his questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement scribes your attitude for the **past week including today,** darken the circle with a 'T' indicating TRUE in the lumn next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' dicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	Ⓣ Ⓕ
2.	I might as well give up because there is nothing I can do about making things better for myself.	Ⓣ Ⓕ
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	Ⓣ Ⓕ
4.	I can't imagine what my life would be like in ten years.	Ⓣ Ⓕ
5.	I have enough time to accomplish the things I want to do.	Ⓣ Ⓕ
6.	In the future, I expect to succeed in what concerns me most.	Ⓣ Ⓕ
7.	My future seems dark to me.	Ⓣ Ⓕ
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	Ⓣ Ⓕ
9.	I just can't get the breaks, and there's no reason I will in the future.	Ⓣ Ⓕ
10.	My past experiences have prepared me well for the future.	Ⓣ Ⓕ
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	Ⓣ Ⓕ
12.	I don't expect to get what I really want.	Ⓣ Ⓕ
13.	When I look ahead to the future, I expect that I will be happier than I am now.	Ⓣ Ⓕ
14.	Things just don't work out the way I want them to.	Ⓣ Ⓕ
15.	I have great faith in the future.	Ⓣ Ⓕ
16.	I never get what I want, so it's foolish to want anything.	Ⓣ Ⓕ
17.	It's very unlikely that I will get any real satisfaction in the future.	Ⓣ Ⓕ
18.	The future seems vague and uncertain to me.	Ⓣ Ⓕ
19.	I can look forward to more good times than bad times.	Ⓣ Ⓕ
20.	There's no use in really trying to get anything I want because I probably won't get it.	Ⓣ Ⓕ

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DAS – 24 (Power et al, 1994)

This scale lists different attitudes or beliefs which people sometimes hold. Please read each statement carefully and decide how much you **agree or disagree** with what it says.
For each of the attitudes please indicate your answer by placing a tick under the column that **best describes how you think.** Be sure to choose only one answer for each attitude. But please note that because people are different, there is no right or wrong answer to these statements.
To decide whether a given answer is typical of your way of looking at things, simply keep in mind what you are like **most of the time.**

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
I fail partly, it is as as being a complete ure.							
others dislike you, cannot be happy.							
should be happy all time.							
eople will probably k less of me if I make istake.							
ly happiness depends e on other people it does on me.							
should always have plete control over my ngs.							
ly life is wasted ss I am a success.							
Vhat other people k about me is very ortant							
ought to be able to e my problems kly and without a t deal of effort.							
f I don't set the est standards for elf, I am likely to end second rate person.							
am nothing if a on I love doesn't love							
A person should be to control what oens to him.							

DAS – 24 (Contd)

ATTITUDES	TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE
If I am to be a ·thwhile person, I st be truly standing in at least major aspect.							
If you don't have er people to lean on, are bound to be sad.							
It is possible for a son to be scolded and get upset.							
I must be a useful, ductive, creative son or life has no pose.							
I can find happiness hout being loved by ther person.							
A person should do l at everything he lertakes.							
If I do not do well all time, people will not ject me.							
I do not need the roval of other people rder to be happy.							
If I try hard enough, uld be able to excel at ything I attempt.							
People who have d ideas are more thy than those who ot.							
A person doesn't l to be well liked in er to be happy.							
Whenever I take a nce or risk I am only king for trouble.							

ATQ

AME _____ Date _____

sted below are a variety of thoughts that pop into people's heads. Please read each thought nd indicate how frequently, if at all, the thoughts occurred to you over the last two weeks. ease read each item carefully and circle the appropriate answers on the answer sheet in the llowing fashion.

= not at all 2 = sometimes 3 = moderately often 4 = often 5 = all the time

	Items	Response				
1	I feel like I'm up against the world	1	2	3	4	5
2	I'm no good	1	2	3	4	5
3	Why can't I ever succeed?	1	2	3	4	5
4	No-one understands me	1	2	3	4	5
5	I've let people down	1	2	3	4	5
6	I don't think I can go on	1	2	3	4	5
7	I wish I were a better person	1	2	3	4	5
8	I'm so weak	1	2	3	4	5
9	My life's not going the way I want it to	1	2	3	4	5
10	I'm so disappointed in myself	1	2	3	4	5
11	Nothing feels good any more	1	2	3	4	5
12	I can't stand this any more	1	2	3	4	5
13	I can't get started	1	2	3	4	5
14	What's wrong with me?	1	2	3	4	5
15	I wish I were somebody else	1	2	3	4	5
16	I can't get things together	1	2	3	4	5
17	I hate myself	1	2	3	4	5
18	I'm worthless	1	2	3	4	5
19	I wish I could just disappear	1	2	3	4	5
20	What's the matter with me?	1	2	3	4	5
21	I'm a loser	1	2	3	4	5
22	My life is a mess	1	2	3	4	5
23	I'm a failure	1	2	3	4	5
24	I'll never make it	1	2	3	4	5
25	I feel so helpless	1	2	3	4	5
26	Something has to change	1	2	3	4	5
27	There must be something wrong with me	1	2	3	4	5
28	My future is bleak	1	2	3	4	5
29	It's just not worth it	1	2	3	4	5
30	I can't finish anything	1	2	3	4	5

Automatic Thoughts Questionnaire

Scoring: add up the scores

Typical depressed group mean = 82
Typical control group mean = 42

Reference:

Hollon, S.D. and Kendall, P.C. (1980) Cognitive Self Statements in Depression: Development of Automatic Thoughts Questionnaire. *Cognitive Therapy and Research*, 4, 383-395.

PENNSYLVANIA STATE WORRY INVENTORY

Directions: **A number of statements which people have used to describe themselves are given below. Read each statement and then circle the number below the statement to describe how you generally feel. There are no right or wrong answers. Do not spend too much time on any statement but give the answer which seems to describe how you generally feel.**

1. **If I don't have enough time to do everything, I don't worry about it.**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

2. **My worries overwhelm me.**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

3. **I don't tend to worry about things**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

4. **Many situations make me worry**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

5. **I know I shouldn't worry about things but I just can't help it**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

6. **When I am under pressure I worry a lot**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

7. **I am always worrying about something**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

8. **I find it easy to dismiss worrisome thoughts**

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

PENNSYLVANIA STATE WORRY INVENTORY

9. As soon as I finish one task, I start to worry about everything else I have to do

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

10. I never worry about anything

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

11. When there is nothing more I can do about a concern, I don't worry about it anymore

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

12. I've been a worrier all my life

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

13. I notice that I have been worrying about things

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

14. Once I start worrying, I can't stop

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

15. I worry all the time

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

16. I worry about projects until they are all done

1---------2---------3---------4---------5
not at all typical of me **very typical of me**

WHOQOL-BREF

Field Trial Version
December 1996

PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANISATION
GENEVA

ABOUT YOU

:fore you begin we would like to ask you to answer a few general questions about yourself by circling the rrect answer or by filling in the space provided

hat is your gender? Male Female

hat is your date of birth? _____ / _____ / _____
Day Month Year

hat is the highest education you received? None at all
Primary school
Secondary school
Tertiary

hat is your marital status? Single Separated
Married Divorced
Living as married Widowed

'e you currently ill? Yes No

something is wrong with your health what do you think it is?
_____ illness/problem

struction
iis questionnaire asks how you feel about your quality of life, health, or other areas of your life. Please swer all the questions.
you are unsure about which response to give to a question, please choose the one that appears most propriate. This can often be your first response.

ease keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in e last two weeks. For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

ou should circle the number that best fits how much support you got from others over the last two weeks. So u would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	(4)	5

ou would circle number 1 if you did not get any of the support that you needed from others in the last o weeks. Please read each question assessment feelings and circle the number of the scale for each uestion that gives the best answer for you

		Very poor	Poor	Neither poor nor good	Good	Very good
G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
G4)	How satisfied are you with your health?	1	2	3	4	5

ıe following questions ask about how much you have experienced certain things in the last two weeks

		Not at all	A little	A moderate amount	Very much	An extreme amount
1.4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
1.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
4.1)	How much do you enjoy life?	1	2	3	4	5
24.2	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
5.3)	How well are you able to concentrate?	1	2	3	4	5
16.1)	How safe do you feel in your daily life?	1	2	3	4	5
22.1)	How healthy is your physical environment?	1	2	3	4	5

ıe following questions ask about how completely you experience or were able to do certain things in the st two weeks

		Not at all	A little	Moderately	Mostly	Completely
2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
18.1)	Have you enough money to meet your needs?	1	2	3	4	5
20.1)	How available to you is the information that you need in your day to day life?	1	2	3	4	5
21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
9.1)	How well are you able to get around?	1	2	3	4	5

ıe following questions ask you to say how good or satisfied you have felt about various aspects of your e over the last two weeks

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
3.3)	How satisfied are you with your sleep?	1	2	3	4	5
0.3)	How satisfied are you with your ability to perform your daily living activities??	1	2	3	4	5
12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
5.3)	How satisfied are you with yourself?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
15.3)	How satisfied are you with your sex life?	1	2	3	4	5
14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
23.3)	How satisfied are you with your transport?	1	2	3	4	5

ae following question refers to how often you have felt or experienced certain things in the last two eeks

		Never	Seldom	Quite often	Very often	Always
3.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

d someone help you to fill out this form? .....

ow long did it take to fill this form out? .....

o you have any comments about the questionnaire? .....

.....

.....

THANK YOU FOR YOUR HELP

office use only _____

	Equations for computing domain scores	Raw score	Transformed score*
main 1	(6-Q3) + (6-Q4) + Q10) + Q15 + Q16 + Q17 + Q18 ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	
main 2	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ ☐ ☐ ☐ ☐ ☐	=	
main 3	Q20 + Q21 + Q22 ☐ ☐ ☐	=	
main 4	Q8 + Q9 + Q12 + Q13 +Q14 + Q23 +Q24 +Q25 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	=	

lease see table on page 9 of the manual for converting raw scores to transformed score

CLIENT SERVICE RECEIPT INVENTORY

LATE LIFE DEPRESSION RESEARCH TRIAL

CSO GRANT NO:K/OPR/2/2/D367

1. CLIENT DETAILS

1.1 Client's Name _____ Identification Number ☐☐☐☐

1.2 Interview Baseline =1, End of treatment =2, 6m Follow-up =4 ☐

1.3 Interview date ☐☐/☐☐/☐☐ (d d m m y y)

1.4 Client's age ☐☐ Primary Carers age ☐☐

1.5 Client's sex Female = 1, Male = 2 ☐ Carers sex Female = 1, Male = 2 ☐

1.6 Primary Carers relationship to client ☐☐

1 Spouse
2 Son/Daughter
3 Son/Daughter-in-law
4 Sibling
5 Other relative
6 Friend
7 Neighbour
8 Other (please specify)
9 Not Applicable

1.7 Marital status ☐☐

1 Single/unmarried
2 Married/living with partner
3 Separated
4 Divorced
5 Widow/widower
6 Not known

1.8 What is/was your occupation?
If interviewee is female determine husband's occupation

_____

1.9 In which of the following categories of accommodation is the client currently resident? ☐

1 Owner-occupied house/flat
2 Privately rented house/flat
3 House/flat rented from housing association/local authority
4 Residential home
5 Nursing home
6 Dual registered home
7 Sheltered housing
8 Other (please specify)

1.9a How many adults live in client's household? ☐

Number of rooms ☐☐

1.9b Do you own a car? YES/NO

2. *INFORMAL CARE*

In the last 6 months, have you received help from **friends or relatives** on any of the following tasks, as a consequence of emotional problems?

Type of help	*Circle*	*Helper's relationship to you (see key below)**	*Average number of hours help per week*	*Average cost per week (£)*
Personal Support *(e.g. company)*	No Yes			
Help in/ around the house *(e.g., cooking, cleaning etc.)*	No Yes			
Help outside the home *(e.g., shopping, transport etc.)*	No Yes			
Other _____	No Yes			

* Key: 1 = Mother; 2 = Father; 3 = Brother/ Sister; 4 = Other Relative; 5 = Friend; 6 = Other (please specify)

3. *SERVICE RECEIPT*

3.1 Please list any use of the following **hospital services** over the last 6 months
(Note: please enter '0' if service has not been used)

Service	**Name of ward, clinic or centre**	**Reason for using service**	**Unit of measure-ment**	**Number of units received (over the last 6 months)**
Assessment/rehab. Ward			Inpatient day	
Continuing care/respite ward			Inpatient day	
Medical ward			Inpatient day	
Other hospital ward (e.g. psychiatric)			Inpatient day	
Outpatient visit			Appointment	
Day treatment			Appointment	
Day hospital			Day attendance	
Other:				

3.2 Please list any use of the following **day services** over the last 6 months
(Note: please enter '0' if service has not been used)

Service	**Name of centre/service**	**Unit of measure-ment**	**Number of units received per week**	**Total number of units received over the last 6 months**
Day care – Local Authority		Days		
Day care - vol.		Days		
Day care – NHS (not hosp.)		Days		
Lunch club		Visits		
Social club		Visits		
Other		State:		

3.3 How does the client travel to day care?

1 Private car ☐
2 Taxi
3 Transport arranged by day service
4 Other (please specify) _____

3.4 Please list any use the client has made of **community-based services** over the last
6 months
(Note: please enter '0' if service has not been used)

Service*	**Domiciliary visit/office visit *(circle one)***	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of non-enhanced hours received (over the last 6 months)**	**Total number of enhanced hours received (over the last 6 months)**
Care manager	DV OV					
Social worker	DV OV					
Home care worker	DV OV					
Care attendant	DV OV					
Sitting scheme	DV OV					
Carer's support worker	DV OV					
District nurse	DV OV					
Occupational therapist	DV OV					

3.4 (continued)

Service*	**Domiciliary visit/office visit** *(circle one)*	**Provider agency (e.g. health, SWD)**	**Total number of visits**	**Average duration of visit (mins)**	**Total number of units received (over the last 6 months)**
Meals on wheels	DV OV				
Laundry service	DV OV				
General practitioner	DV OV				
Community psychiatrist	DV OV				
Geriatrician	DV OV				
Psychologist	DV OV				
CPN	DV OV				
Health visitor	DV OV				
Occupational therapist	DV OV				
Physiotherapist	DV OV				
Chiropodist	DV OV				
Other: e.g. complementary therapies, counsellor, aroma-therapist, dentist					
1.	DV OV				
2.	DV OV				
3.	DV OV				
4.	DV OV				

3.5 Please list any use of **privately arranged services** paid for by the client over the last 6 months
(e.g. gardening, cleaning)

Specify service	**Unit of measurement**	**Number of units received (over the last 6 months)**	**Total cost)**

4. *INCOME SOURCE*

4.1 Does the client receive any of the following benefits? *(Please tick all boxes that apply)*

- Income support, income-based jobseeker's allowance ☐
- Housing benefit ☐
- Council-tax benefit ☐
- Incapacity benefit ☐
- Severe disablement allowance ☐
- Invalid care allowance ☐
- Attendance allowance ☐
- Disability living allowance ☐
- Retirement pension ☐
- Other _____ ☐
- Total benefits received ☐☐

4.2 What is your main income source?

1 Salary/Wage
2 State benefits
3 Pension – occupation/state
4 Family support (eg from spouse)
5 Other ☐

5. Please list below use of any drugs taken for <u>emotional problems</u> over the <u>last six months</u>

Name of drug	*Dosage (if known)*	*Dose frequency (e.g. daily)*	*For how long have you taken this drug?*
1.	*mg*		
2.	*mg*		
3.	*mg*		
4.	*mg*		
5.	*mg*		

THANK YOU

MENTAL STATE ASSESSMENT

Name **Date**

ORIENTATION: Score 1 point for each correct answer to following

Time? **Date?** **Day?** **Month?** **Year?** (_____)

PM? **Monarch?** **Town?** **District?** **Country?** (_____)

REGISTRATION: Examiner names 3 objects. Score up to 3 points if, on the first attempt, the subject repeats, in order, the 3 objects. Score 2 or 1 if this is the number of objects he repeats correctly. Use further attempts and prompting to have all 3 repeated, so as to test recall later. (_____)

ATTENTION & CALCULATION: Ask the subject to subtract 7 from 100, then 7 from the result – repeat this 5 times, scoring 1 point for each correct subtraction (max. score 5 points). **OR** ask the subject to spell "WORLD" backwards. (_____)

RECALL: Ask for the 3 objects named in the registration test scoring 1 point for each. (_____)

LANGUAGE:
Score 1 point for each of two objects (pen & watch) correctly named. (_____)

Score 1 point for the correct repetition of this phrase (_____)
"No ifs, ands or buts"

Score 3 if a three-stage command is correctly executed or 1 for each stage. **"With the index finger of your right hand touch the tip of your nose and then your left ear"** (_____)

On a blank piece of paper write **"CLOSE YOUR EYES"**. Ask the subject to obey. Score 1 point. (_____)

Ask the subject to write one short sentence with a ***subject*** and a ***verb.***
Score 1 point. (_____)

CONSTRUCTION & SPATIAL SENSE: Construct a pair of intersecting pentagons each side one inch long (see below). Score 1 point if this is correctly copied. (_____)

TOTAL SCORE (maximum 30) (_____)

APPENDIX EIGHT:

SCORING CRITERIA FOR OUTCOME MEASURES

Scoring criteria for measures

BDI-II:

0-13	Minimal/asymptomatic
14-19	Mild
20-28	Moderate
29-63	Severe

BHS

0-3	Minimal/asymptomatic
4-8	Mild
9-14	Moderate
15-20	Severe

HRS-D 17 item

0-6	Normal
7-17	Mild
18-24	Moderate
25+	Severe

ATQ

Typical depressed mean score = 82
Typical group mean (control) = 42

DAS 24

Every item on the DAS is score from 1 to 7. Depending upon whether the particular item is scored in the forward direction or the backward direction.

Items 17, 20, 23 are scored in the forward direction. That is, Totally agree = +1, Agree very much = +2, Agree slightly = +3, Neutral = +4, Disagree slightly = +5, Disagree very much = +6, Totally disagree = +7

The total score on the DAS 24 is obtained by summation of the item scores for each individual statement. The 3 subscales scores are obtained from the following sets of statements:

Achievement	Dependency	Self-Control
1	2	3
4	5	6
7	8	9
10	11	12
13	14	15
16	17	18
19	20	21
22	23	24

Missing items on the DAS 24 should be coded as zero. However should the individual omit half or more of the items on one of the subscales, then that sub-scale should be

ignored. In a similar manner, if half or more of the total scale items are omitted, then the overall scale should be ignored.

PSWI

16 item scale assessing an individual's general tendency to worry excessively. The PSWI was designed to specifically assess the intensity and excessiveness of worry with reference to specific content of worries. Each item presents a statement and is followed by a 5-point likert –type response scale representing how typical the individual feels that the statement is for him or her.

Items 1, 3, 8, 10 & 11 are reverse scored and all 16 items are summated. Possible scores range from 16 to 80. Gayle Beck and Melinda Stanley have assessed the PSWI with older people and in 1995 published a paper that showed a mean score of 59.9 (11.5) for older people with GAD.

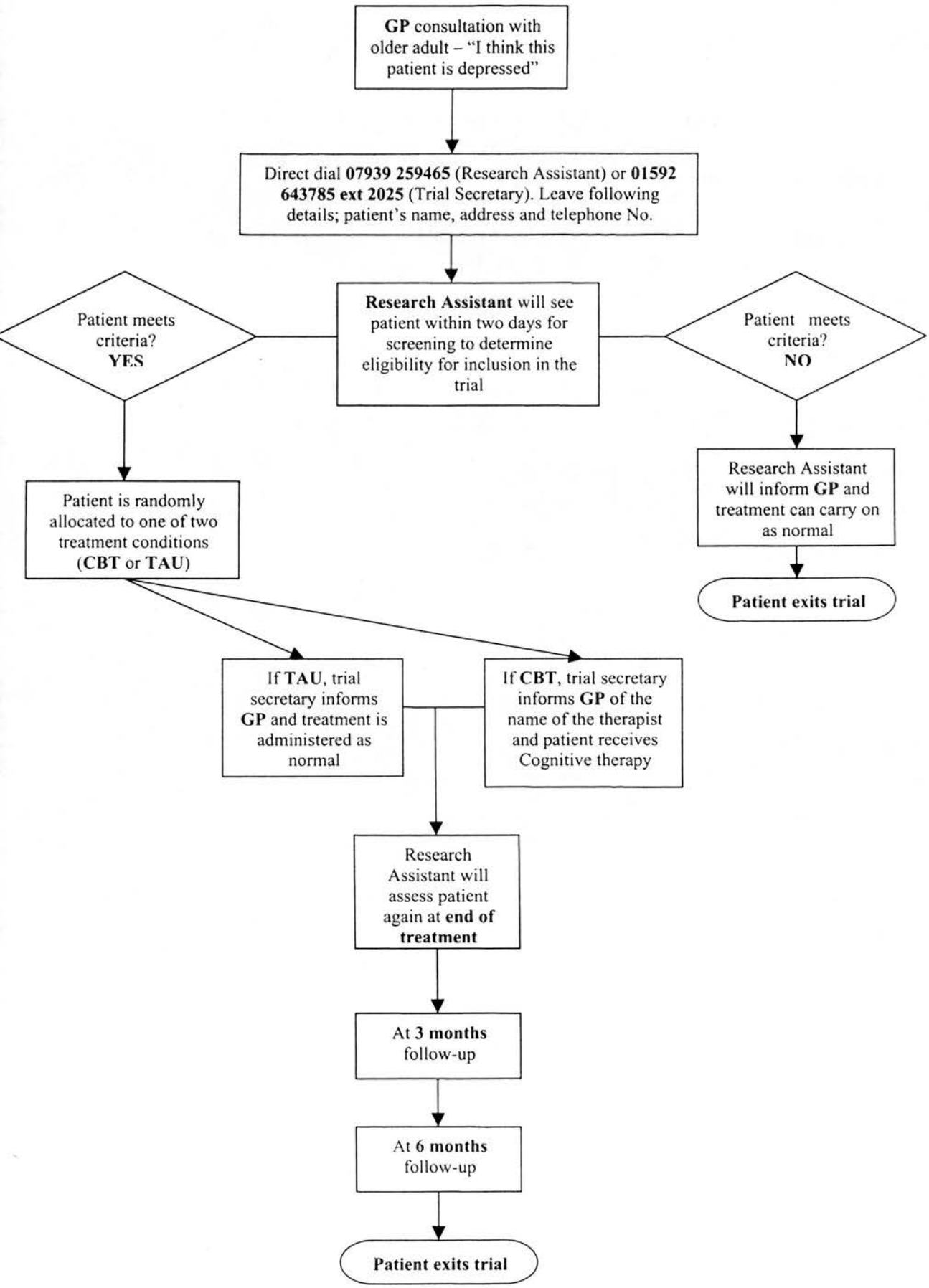
Registrar General's Social Scale for 1990

Social Class I: Professional occupations
Social Class II: Managerial and technical occupations
Social Class III (NM): Skilled occupations (non-manual)
Social Class III (M): Skilled occupations (manual)
Social Class IV: Partly skilled occupations
Social Class V: Unskilled

APPENDIX NINE:

SUMMARY OF RESEARCH PROTOCOL

LATE LIFE DEPRESSION RESEARCH TRIAL



APPENDIX TEN:

COGNITIVE THERAPY TREATMENT MANUAL

Cognitive-Behavioural Therapy for Late Life Depression:

A Therapist Manual

Authored By:

Larry W. Thompson, Ph.D.,
Dolores Gallagher-Thompson, Ph.D.,
Leah P. Dick, Ph.D.

Authorised UK Version Prepared by:
Ken Laidlaw

COGNITIVE-BEHAVIOURAL THERAPY

FOR LATE-LIFE DEPRESSION:

A THERAPIST MANUAL

Authored by:

Larry W. Thompson, Ph. D, Dolores Gallagher-Thompson, Ph.D.,

and Leah P. Dick, Ph.D.,

Older Adult and Family Research and Resource Center

VA Palo Alto Health Care System

and Stanford University School of Medicine

Authorised UK Version updated, revised & prepared by Ken Laidlaw

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A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression

Research funded by the Chief Scientist Office (CSO) Scotland,Grant Reference Number K/OPR/2/2/D367

UKVersion 1.2: 06/2000

Contents

COGNITIVE-BEHAVIOURAL THERAPY FOR LATE-LIFE DEPRESSION: *A THERAPIST MANUAL*

The original US manual, and the accompanying client version was developed while the authors (Thompson, Gallagher-Thompson & Dick, 1997) were affiliated with the Older Adult and Family Research and Resource Center which is part of the GRECC-Geriatric Research, Education, and Clinical Center- and the Psychology Service of the VA Palo Alto Health Care System and Stanford University.

For permission to duplicate the US materials, as well as for further information about programs offered by the Older Adult Center, or to correspond with the staff there, please use the following mailing address:

Dr. Dolores Gallagher-Thompson or Dr. Larry W. Thompson,

Co-Directors, Older Adult Center (mail code: 182C/MP)

VA Palo Alto Health Care System

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Our FAX number is: (650) 617-2778

This version of the manual has been specifically adapted by KL for use by therapists as a treatment guide in the Scottish Office funded Late Life Depression research trial. (K/OPR/2/2/D367). *Do not copy this manual in part or whole without express written permission from the UK author.*

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We wish to thank all of the clients and patients of the Older Adult Center in particular (and the VA, more generally) for their patience and persistence while we developed and refined our therapeutic treatment interventions. We appreciate all the feedback you have given about our approach; it has helped considerably to improve our work.

We also wish to thank Aaron T. Beck, M.D., and associates for their initial belief in our efforts and continued support and encouragement over the years. Through our contact with this group of professionals over the past decade, many new insights were gained that have been modified and integrated within our general framework, in order to improve our effectiveness in treating depression and related affective disorders in older adults.

Finally, we wish to extend our appreciation to the VA Palo Alto Health Care System (in particular, the Psychology service) for supporting our work and enabling our team of clinicians and researchers to find a professional "home" in which we could cultivate our ideas, and thrive in their application.

Ken Laidlaw wishes to acknowledge the kind permission granted by Dolores Gallagher-Thompson and Larry Thompson to modify the original therapist manual and to use this version in the first UK randomised controlled trial of individualised CBT for late life depression. The UK author acknowledges thanks to Professor Mick Power of Edinburgh University for helpful comments on early draft versions of this manual. I wish to mirror the US authors in acknowledging my debt to the many older people I have worked with and from whom I have learned a great deal. I also acknowledge the support and encouragement given to me over the years by Hugh Toner, Area Head of service, Fife Primary Care NHS Trust. Finally I thank Jim Law for the work he has done to support this project.

Notes on the UK CBT for Late Life Depression Manual

This version of the original US manual prepared by Larry Thompson, Dolores Gallagher-Thompson, and Leah Dick has been updated, expanded and revised with particular emphasis being applied to the use of this manual in a randomized controlled trial of CBT versus Treatment as Usual for Late Life Depression. There are a number of similarities with the original US manual but there are also a number of significant differences, most notably in the ordering of chapters, content of chapters and the addition of new chapters. Some parts of existing chapters were revised to take into account differing cultural expectations, particularly the removal of the Pleasant Events Schedule and the more extensive use of the weekly activity schedule.

The chapter on behavioural interventions has been revised and now does not use the pleasant events scale. The chapter on cognitive interventions (thinking skills) has been expanded and updated. The chapter on anxiety has been expanded and revised to include sections on worry and on insomnia. The chapter on relaxation methods has been extended to include a fuller description and guide to differential relaxation techniques. There are three new and additional chapters; on formulation, on identifying and modifying dysfunctional attitudes and beliefs, and a final chapter entitled troubleshooting. The introductory section of the manual includes use of UK demographic data and also includes information for therapists about the late life depression research trial. A number of clinical examples have been changed to reflect a UK perspective.

HOW THIS MANUAL IS TO BE USED

This manual was developed to provide therapists from varying backgrounds (such as psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors) with a clearly written guide for conducting cognitive-behavioral therapy with older adults. There is a companion manual which our group also developed that is intended to be used by the clients them selves and we strongly recommend that they both be used **together** rather than either one alone.

Late Life Depression Study: Important notice

This manual should be thought of as a guide for therapists and should not be used prescriptively or rigidly. The essence of 'good' cognitive therapy is that it should be individualized to suit your patient's circumstances. However, within this clinical autonomy there are important issues of **standardization** of treatment across therapists and between treatment sites. The manuals are an aid to the process of standardisation

This work is a product of over a decade of experience treating older adults on an outpatient basis with primary diagnoses of affective disorders, particularly eposodic or chronic depression and/or a variety of anxiety disorders such as simple phobias or agoraphobia. We have found it necessary to develop these very explicit and detailed manuals because of their effectiveness in helping both the therapist and the client to stay on track and more readily accomplish their goals.

Feedback from a number of therapists and clients over the years has been incorporated into these manuals. Therefore, we believe that we have achieved clarity of presentation, along with thoroughness in our presentation of the concepts and techniques that are critical to success in time limited cognitive hehavioral therapy. We would welcome your comments and those of your clients in how to improve upon these manuals so that we can revise them at least every two years, thereby making them as relevant as possible to the changing face of mental health in this country.

BACKGROUND INFORMATION

Our societies (US/UK) define older people as persons who are aged 65 years and above. In 1989, 31.0 million people in the United States were over 65, (10.6 million in the UK) which was approximately 13 percent of the total U.S. population, roughly about one in every 8 of the baby boom generation will reach "old age" (AARP, 1990). In the UK in 1997, 18 per cent of the population were over pensionable age. In Scotland in 1996 there were 917 000 older people. It is estimated that by 2020 there will be twice as many people aged 60 and above living in the European Community than there were in 1960. Depression is the most common psychiatric disorder amongst older adults. Prevalence studies consistently indicate symptoms of depression occurring in up to 15 per cent of adults resident in the community aged 65 years and above. While depression amongst older people is 2-3 times more common than dementia, older people do not necessarily demonstrate depression and depressive symptoms more frequently than younger adults. Importantly, the vast majority of older people are not depressed even when confronted by a change in their circumstances.

Chronological vs. Functional Age

In working with older adults, it is important to understand the individuality of each older person you see. Therefore, it is important to understand the difference between chronological age and functional age.

Chronological age: This is the years since birth. It is a categorical number, but it does not provide accurate information regarding an older adults individual capabilities

Functional age: Functional age represents the integration of biological, social, and psychological functional capabilities.

Biological age represents where the individual is in relation to his/her potential life span. Social age refers to the person's roles and behavior relative to his/her peer group. Psychological age refers to how individuals cope with the changing environment. Examples of abilities that comprise one's psychological age are cognitive functioning, ability to cope with stress, self-esteem etc.

The Importance of Cohort

Cohort refers to the set of cultural norms, historical events, and personal events that occurred during a specific generation. Each generation can identify specific sociocultural factors influencing their style of coping with problems, family relationships, as well as a general outlook on life. For example, today's older adult would be affected by the Great Depression, WWII, etc. Understanding older people in terms of their cohort becomes an essential part of developing the therapeutic relationships especially if you yourself are considerably younger. Showing an interest on how both individual views the nature of the problems at hand, as well as the coping style they are familiar with can only enhance the older adult's perception that he/she is being respected.

The treatment of depression in later life (UK perspective)

Often there are low expectations regarding the outcome of treatment for depression in this age group which very often leads to under-diagnosis and either no treatment or subtherapeutic dosaging of medication. Although GPs are good at identifying depressive symptoms amongst older adults, it does not necessarily follow that when depression is identified by GPs that the older person will receive treatment for this illness. More recently researchers reported that GPs were aware of depression in half of their patients aged 65 years and above, but active levels of management were very low. There are a number of reasons put forward for this. It is often presumed that depression is a natural consequence of the losses experienced by this population in terms of emotional attachments, physical independence and socioeconomic hardships. This 'understandability phenomenon' afflicts both patient and doctor alike and often effective treatment alternatives are dismissed prematurely.

A combination of low expectation of treatment success and a fear of possible negative effects from antidepressant medication often leads to a high incidence of prescriptions of subtherapeutic dosages of antidepressant medications. The combination of variability of drug metabolism in elderly people and the fact that a substantial proportion of elderly depressed people may also be physically ill and frail, and are taking combinations of other drugs often results in the prescription of subtherapeutic doses of medication, or no treatment at all despite the fact that treatment is indicated. Another

difficulty with pharmacological treatment of depression in older adults is that people are often reluctant to take medication and very often favour psychosocial approaches instead.

Evidence for the effectiveness of cognitive-behavioural approaches with older people

Reviews of outcome research into psychological treatment approaches for depression in older adults have generally suggested that cognitive therapy (CT) is an effective therapeutic approach. Scogin & McEreath (1994) in a meta analytic review of the effect of psychosocial treatment for late life depression note that effect sizes for treatment versus no treatment or placebo were substantial. In the most specific review looking at outcome research into strictly defined cognitive therapy for the treatment of depression in older adults, Koder, Brodaty & Anstey (1996) identified that cognitive therapy was an effective treatment approach with older adults. Gerson, Belin, Kaufman, Mintz, & Jarvik, (1999) provided evidence that medication and psychological treatments are equally efficacious in the relative reduction on quantative measures of mood between treatments. Analyses also revealed no significant difference in attrition rates between medication and psychological treatments. Table 1 contains a summary of the results of meta-analyses investigating the effectiveness of psychological treatments for late life depression.

Table 1: Summary of meta-analyses studies

Authors	Years reviewed	No. of studies in analyses	Effect sizes	Conclusions
Scogin & McElreath (1994)	1970-1988	17 Broad categorisation of treatments	Overall effect size for treatment versus no-treatment or placebo is 0.78.	No clear superiority for any system of psychotherapy in the treatment of geriatric depression.
Koder, Brodaty & Anstey (1996)	1981-1994	7 All CT studies	CT vs BT mean effect size is 0.26 CT vs PP mean effect size is 0.41 CT to WL mean effect size is 1.22	Too few studies of sufficient scientific and methodological merit upon which a definitive conclusion can be reached about the relative efficacy of CT over other treatments but CT is undoubtedly an effective treatment option for late life depression.
Engels & Verney (1997)	1974-1992	17 studies - all patients carry diagnosis of MDD	Mean effect size of 0.63 (i.e client was on average 74% better off than non-treated controls)	Individual treatment more effective than group methods of treatment for depression in older people.
Cuijpers (1998)	1981-1994	14 psychological treatments.	Effect size of 0.77 comparable to that found in younger samples	"Effects of interventions in which the depressed elderly are actively recruited from the community are large. These effects are comparable to the effects of psychotherapy of depression in younger age groups."
Gerson, Belin, Kaufman, Mintz, & Jarvik (1999)	1974-1998	45 (4 non-drug) 28 (2 non-drug)	Drug and non-drug treatments appear equally efficacious. No difference in results if use stricter criteria for studies	"Effective psychological interventions constitute a much-needed addition to antidepressant medication for depressed older patients."
Robinson *et al* (1990)*	1976-1986	58 studies	Overall effect size for treatment versus no-treatment is 0.73.	All forms of psychotherapy more effective than no treatment. Differences in efficacy of psychotherapies disappear when take therapist allegiance into account.

CT = cognitive therapy; BT = behaviour therapy, PP = Psychodynamic psychotherapy. N.B. Cohen (1992) recommends that for the behavioural sciences, effect size of 0.8 is large, 0.5 is moderate, 0.2 is small. * = *for comparison of outcome between age groups*

A summary of the main studies looking at CT for older adults is provided below in table 2. Studies are included in table 2 if they include cognitive-behavioural treatment for late life dpression and if they report data using the Beck Depression inventory (BDI: Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) and the Hamilton Rating Scale for Depression (HRSD: Hamilton, 1967). In the eight studies included in table 2, most of the studies report no significant differences in efficacy between active treatments with a few exceptions. A general point to note in table 2 is that in every case using BDI data, cognitive-behavioural methods of treatment produce the largest effect sizes of treatments within each study. Thus while significant differences may not always be apparent there is evidence that cognitive therapy may be the most effective treatment for late life depressio

American and British Older People Demographic Fact Sheet

American Information obtained from AARP, (1990), and U.S. Bureau of Census (1988). The UK information was drawn from the UK General Household Survey (1994) and from Age Concern (2000).

- **Older men are twice as likely to be married than older women**

In the UK in 1996:	For men aged 65-74	For men aged 75 plus
	74 per cent were married	62 per cent were married
	For women aged 65-74	For women aged 75 plus
	53 per cent were married	28 per cent were married

- **Half of all older women are widows**

In the UK in 1996:	For men aged 65-74	For men aged 75 plus
	13 per cent were widowed	29 per cent were widowed
	For women aged 65-74	For women aged 75 plus
	35 per cent were widowed	62 per cent were widowed

- **Two thirds of older adults live with their families, which may be a spouse, child, sibling**

In the UK in 1994	39 per cent of older people lived alone
	39 per cent of older people lived with their spouse only

- **In the USA only 5 percent of all older people live in nursing homes**

In the UK in 1994	7 per cent of older people lived in nursing homes
	10 per cent lived in sheltered housing accommodation

- **90% of U.S. elderly are Caucasian**

In the UK in 1997 people from ethnic minority groups represented just over 6 per cent of the older adult population.

- **In 1989, the median income for households headed by older adults was $23,179**

  12% of households reported incomes below $10,000

  36% of households reported income over $30,000

- **Income for older adults comes from the following sources:**

  Social Security, Earnings, Personal savings, Pension plans

In the UK in 1997, 70 per cent of pensioner households were dependent upon state benefits for at least 50 per cent of their income, and 13 per cent received all their income from state benefits. (the basic pension from April 1999 – April 2000 is £66,75 per week for a single person's pension, and £106.70 per week for a married couple's pension).

- **Older adults report greater health concerns than younger adults**

In the UK in 1994 39 per cent of older people rated their health as good over the previous 12 months.
23 per cent rated their health as being poor within the last 12 months

In the UK in 1994 59 per cent of older people reported a long-standing illness, disability or infirmity.
40 per cent reported this condition limited their activities.

In the UK in 1994 97 per cent of older people reported using spectacles or contact lenses. 20 per cent reported difficulties seeing even when using eyesight correctives.

In the UK in 1994 12 per cent of older people wore a hearing aid.

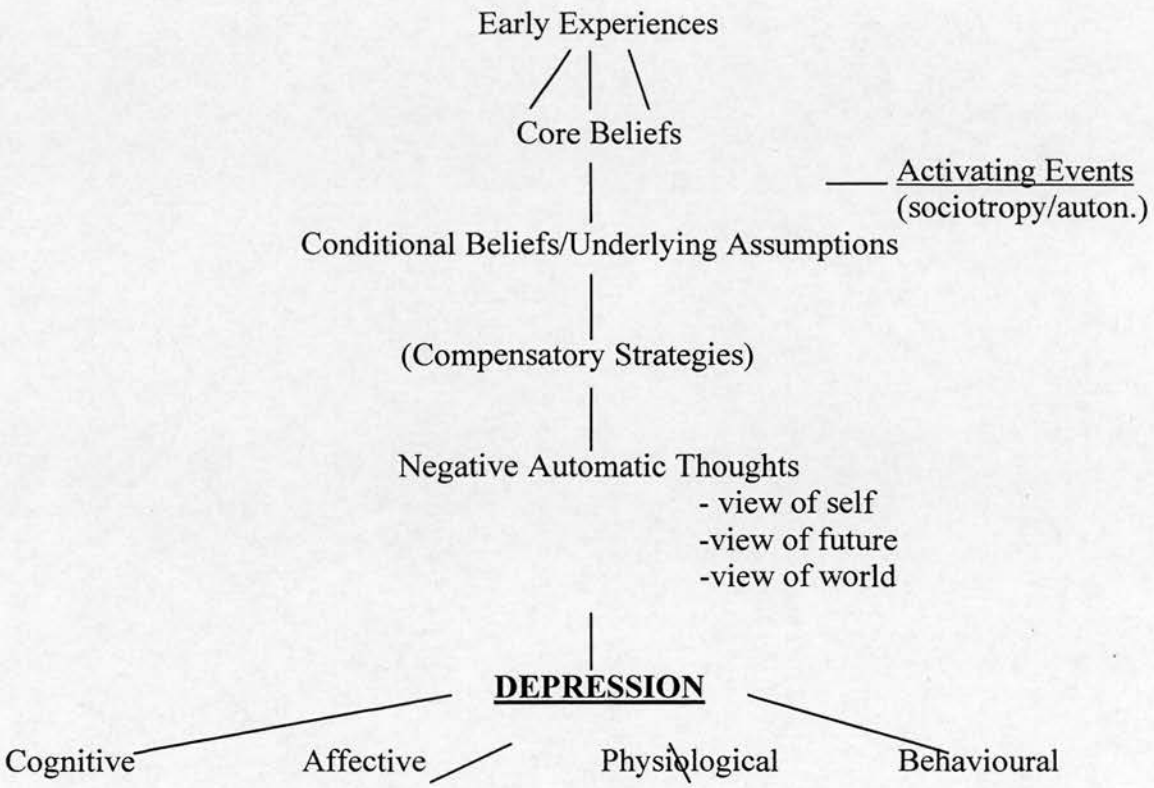
23 per cent reported experiencing hearing difficulties but did not use hearing aids.

- **33% of all hospital stays are older adults and in then UK these stays are generally longer for older people.**

Cognitive Therapy Basics in Working with Older Adults

Please take a moment to review these basics before you turn to the clinical sections of this manual.

Beck's model for depression states that a depressed person's mood and behaviour are largely determined by the way in which they view the world. The depressed person's habitual or idiosyncratic way of making sense of things is largely determined by their experiences as they developed and matured. If a person should meet with a stressor or personally meaningful event which matches their vulnerabilities they may be at risk of developing depression. This model is outlined schematically below:



Cognitive therapy's aim is to identify and modify cognitive errors in a depressed person's thinking. At later stages in therapy, the focus may turn to identify and modify deeper issues in therapy such as underlying dysfunctional assumptions and core beliefs.

Cognitive therapy is a structured psychotherapy. The structure within a cognitive therapy session will have a consistency across sessions and this should be apparent to your client. Even when discussing markedly different topics you can use the same basic structure across your cognitive therapy sessions. Using an agenda is essential to ensure continuity between sessions. Evidence from research suggests that effective therapies are characterised by their use of highly structured sessions. However, therapists can often feel uncomfortable setting an agenda. Beck (1995) suggests this discomfort is due to negative predictions such as; my client won't like it; this is too rigid & I could miss important topics; my client will feel controlled, etc.

A typical structure for your cognitive therapy session will include the following elements:

Agenda Setting

Brief update - Probe question: "How have you been over the last week?"Aim of probe question is to help set up agenda for current session.

Bridge sessions, "What thoughts did you have about our last meeting?"

Identify session's targets. "What sorts of things should we talk about today?" Follow up with, "If we put these items on our agenda today will that cover most of the things which are important to you right now?" Optional: 'mood check' especially if person appears quite hope-less about their situation.

Review of Homework

Identify if person has complied with homework and how they have found it: "I'd be interested to hear how you have got on with the task we agreed upon last time." Put homework on agenda as the first item for discussion.

Prioritization and discussion of session's targets

If agenda has a number of points then ask client to help you prioritize Always ask for feedback at end of session.

Discussion and assignment of further homework.

Homework should be personally important and relevant to the individual and to the topics being discussed. It should take topics further. It is good practice to check peoples' understanding of the rationale for the homework task. A good question to ask is. "What do you think you might gain by doing this task?"

Elicit feedback from the patient

It is important to spend some time at the end of your session to explore any misconceptions that may have arisen. It is useful to check on your client's thought about your session.

The model of cognitive therapy for older adults is considered 'standard' cognitive therapy. The following lists a number of reasons why the CBT used in this manual is not considered 'different' from that applied to adults under the age of 65 years.

Evidence that older adults can benefit from CT without adaptations to the model

At present there is no empirical evidence that suggests adaptations are required in order to make cognitive therapy an effective treatment for older people (Laidlaw, 1999). Indeed, the most systematic outcome research published to date by Thompson and colleagues (Gallagher & Thompson, 1983; Thompson, Gallagher & Breckenridge, 1987; Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990) has demonstrated the effectiveness of standard cognitive therapy for treating depression in older people.

There are two essential pieces of evidence from the empirical literature suggesting that the clinician should be cautious about drawing the conclusion that in order for cognitive therapy to be effective with older people it requires to be adapted. The first piece of evidence against adaptation of CT comes from the meta-analysis literature. Results of meta-analyses carried out in older adult populations report near identical effect sizes to those reported by meta-analyses studies looking at CT across all age groups. The second piece of evidence suggesting that adaptations do not necessarily require to be made in order for CT to be effective with older adults comes from the literature on outcome

studies. Again here outcome studies produce similar results in older adults receiving CT in comparison to findings reported from studies looking at the under 65 year old population. Thus the conclusion to be reached from these two pieces of evidence is that CT is equally efficacious in younger and older age groups and this is using CT *without* adaptations[1].

Zeiss & Steffen (1996) have suggested some considerations for therapist who might be considering practising cognitive behavioural therapy with older adults which are entirely consistent with the model of CT. They have suggested the use of a mnemonic, MICKS (Multimodal, Interdisciplinary awareness, Clearer, Knowledge of aging challenges and strengths, Slower). None of the suggestions made by Zeiss & Steffen (1996) are inconsistent with the research literature. There is an important distinction to be made here between adaptations and treatment guidelines. Guidelines such as those suggested by Zeiss & Steffen (1996) are intended to enhance treatment outcome within the model of therapy (i.e. CT), whereas adaptations are intended to alert clinicians to the possibility that the treatment model they have chosen may not be adequate for the circumstances. It is this position that lacks any evidence and it is this position that needs to be explicitly challenged. The practice of cognitive therapy has always been evidence-based and evidence-driven, that must remain regardless of the population CT is applied with. For older adults who are often inadequately treated for depressed this is a very important issue.

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[1]. The assertion being made is that adaptations are not necessary for cognitive therapy to be effective with older people, this position is not necessarily advocated when working with very frail older adults (Grant & Casey 1995) or those with cognitive impairment (Bechtle-Higgins, Snow, Powers & Cook, 1999).

The idea that CT has to be adapted for use with older people has another very unfortunate side-effect. The large body of empirical evidence accumulated over the years demonstrating the effectiveness of CT as an effective treatment alternative to antidepressant medication is disregarded because of questions about relevance. Thus a very useful body of literature is needlessly thrown away. Therapists, service providers, referring agents (GPs) and patients themselves are not recognising that a mainstream effective treatment alternative to antidepressant medication and ECT *currently exists* for the treatment of depression in older people. This is a state of affairs that cannot and should not be allowed to continue.

The strength of cognitive therapy is that it is based upon an individual formulation to aid understanding of the individual's circumstances. There is no need to suggest major therapeutic adaptations in most circumstances as all CT is 'tailor-made' and adapted to suit the individual circumstances. As Beck (1995) suggests, cognitive therapy is based upon a constantly evolving formulation of the person and their perceived problems in terms of a cognitive conceptualisation. To suggest that adaptation are required to make cognitive therapy effective with older people ignores the heterogeneity of this population, this is both ageist and thoughtless.

The Late Life Depression Research Trial

It is important to bear in mind that the late life depression research trial is not simply an efficacy trial but it has important elements more commonly associated with an effectiveness trial. In effect this means that participants in the study will not necessarily be monosymptomatic. It is anticipated that participants will often have significant issues of comorbidity as the presence of physical illness and anxiety disorders are not exclusion criteria.

The full inclusion and exclusion criteria are set out below:

Inclusion criteria

1. Be aged between 60 - 89 years.
2. Achieve *primary* diagnosis of depression using DSM IV diagnostic criteria for Major Depressive Disorder (structured diagnostic interview: SADS-L)
3. Have Beck Depression Inventory (BDI) scores and Hamilton Ratings scale for depression (HRSD) scores placing them within mild to moderate depression range.
4. Be able to give written informed consent.

Participants will be excluded from the trial using the following criteria:

1. Insufficient knowledge of English to enable them to be assessed adequately and to satisfactorily provide written informed consent to treatment.
2. Participants exhibiting psychotic features, evidence of organic pathology (MMSE <22) or currently undergoing ECT for late life depression.
3. Have Beck Depression Inventory (BDI) scores and Hamilton Ratings scale for depression (HRSD) scores placing them within severe depression range.
4. Participants who are currently receiving systematic psychological therapy, or who start it during the course of the study
5. Participants who are already receiving antidepressant medication prior to entering the treatment trial

There are two treatment conditions within this research trial; CBT or TAU (also known as standard treatment)

TAU alone

Participants in this condition will receive the treatment that they would normally be offered. There will be no constraints upon standard practice other than the exclusion of structured psychological treatment aimed directly at the allevation of depressive symptoms. In TAU each case can be managed within a multidisciplinary team. TAU can include any combination of physical treatment for depression, such as antidepressant medication, physical review, referral to CPN or other services deemed appropriate (i.e. OT) and social services. It is important that TAU is as close to TAU as possible and requires that the actual management of depression is carried out in the community using standard delivery models. Participants referred to CPN services as part of their TAU component of treatment will not receive cognitive and behavioural interventions

CBT alone

Participants randomly allocated to this group will receive up to 20 sessions (spread over an 18 week period) of cognitive behavioural therapy for late life depression. At start of treatment each participant will attend for CBT weekly for the first four weeks and thereafter either weekly or fortnightly for a minimum of 8 sessions and a maximum of up to 20 sessions as appropriate.

The following measures have been agreed:

Measures	Baseline	6wks	12wks	18wks(END)	3mth	6mths
Beck Dep. Inventory	Yes	Yes	Yes	Yes	Yes	Yes
Ger. Depress. Scle (GDS)	Yes			Yes	Yes	Yes
Beck Hopelessness Scle	Yes	Yes	Yes	Yes	Yes	Yes
Hamilton Rtng Scle Dep	Yes			Yes	Yes	Yes
Dys. Attitude Scle (DAS)	Yes			Yes	Yes	Yes
Auto. Thgt. Q'aire (ATQ)	Yes			Yes	Yes	Yes
Penn Worry Q'aire (PSWQ)	Yes			Yes	Yes	Yes
CSRI	Yes			Yes	Yes	Yes
QOL- Brief	Yes			Yes	Yes	Yes
SADS-L	Yes					
LIFE II PSR	No			Yes	Yres	Yes
NART & MMSE	Yes			Yes	Yes	Yes

Therapists should note that all measures (even within sessions assessment such as 6 & 12 week BHS & BDI ratings) are being collected by the research assistants attached to each site. The outcome of the assessment will be recorded in your patient's individual case file. **Please note it is essential you do not directly contact the research assistants about your individual patients.** It is crucial that the research assistants remain blind to treatment condition. If you have any queries regarding your patient's assessment please direct them in the first instance to Ken Laidlaw and he will obtain information as appropriate from the main research database.

Rating of tapes

Each session you complete with your client should be audiotaped and used initially during any supervision sessions. A selection of audiotapes will be checked for treatment integrityand standardisation purposes by either Ken Laidlaw (for Glasgow therapists) or Kate Davidson (for Fife therapists). A random selection of audiotapes will be double-rated at the Beck Institute in Philadelphia. **This is a standard feature of this type of psychotherapy research and should not be viewed as doubts as to your therapeutic competence**. Remember that as long as you adhere to basic principles in cognitive therapy, your sessions are very likely to be judged as acceptable within our criteria of treatment fidelity and standardization.

Informed Consent

This aspect of participation in the trial is handled by the research assistants as part of the standard screeing process. See over for an example of the informed consent form your patient will have completed.

Information Sheet

A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression

Mr. Ken Laidlaw, Mr Hugh Toner, Dr Stella Clark.
Fife Primary Care NHS Trust: Department of Clinical Psychology and Department of Old Age Psychiatry

We would like to invite you to take part in a research study which compares a psychological (talking) treatment with standard treatment for depression. We are interested in finding out if the two treatments are equal in helping people to overcome depression or if one might be better. For adults under 60 years of age, we know both treatments are successful treatments for depression. We do not know the answer to this for adults over 60 years of age. This is the reason for this study.

In this research study everyone will be offered treatment for their depression. The treatment you receive will be randomly selected, i.e. we do not know at this stage which treatment you will receive. If you are selected for psychological treatment (cognitive therapy) you will receive up to 20 sessions of therapy lasting one hour each over a six month period ***(the course of treatment may be shorter and depends upon personal circumstances).*** If you are selected for standard treatment this is the treatment you would usually have received and this may be carried out by your doctor (GP) or by a nurse who works in the community. This may involve medication and regular follow-up over six months.

The research will involve taking part in an interview just prior to the start of the study and at the end of treatment and at two other times; at three and six months after the end of treatment. During these interviews you will be asked to complete some questionnaires. We also ask your permission to collect some information on your health service contacts

from your GP. Approximately half of the patients in this study will have their sessions audiotaped by their therapist. This is a check on your therapist to ensure they are doing the treatment correctly. The audiotapes are confidential and will only be listened to by professional staff involved in the research. At the end of the study the tapes will be destroyed.

You are free to refuse this invitation. If you decide not to take part in this research your clinical treatment will not be affected in any way. If you do decide to take part in this research but later, change your mind, you are free to withdraw from this study at any time and this will not affect your right to future NHS treatment or care.

Prior to deciding, we would recommend that you think about it for a few days and read the information provided here. You can also contact a member of the research team who will be happy to answer any of your queries. There will also be time to ask questions when you come for interview.

If you have any queries please contact:	*Telephone Numbers*
Ken Laidlaw Principal Investigator	0131 537 6277 (direct line) Mon - Tues
Department of Clinical Psychology Stratheden Hospital	01334 652611 ext. 336 Wed - Fri
Cupar, Fife. KY15 5RR	Email: k.laidlaw@ed.ac.uk

PATIENT INFORMED CONSENT FORM:

Fife Primary Care NHS Trust

Department of Clinical Psychology and Department of Old Age Psychiatry

Mr. Ken Laidlaw, Mr Hugh Toner, Dr Stella Clark.

A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression

PATIENT NAME.....DATE OF BIRTH.....

To be completed by the patient:

	please circle one	
Have you read the patient information sheet?	YES	NO
Have you had the opportunity to ask questions and to discuss this study?	YES	NO
Have you received satisfactory answers to all your questions?	YES	NO
Have you received enough information about the study?	YES	NO

Whom have you spoken with? Dr/Mr/Ms_____

Do you understand you are free to withdraw from this study:

At any time and without having to give a reason	YES	NO
AND without this affecting your future medical care	YES	NO
Do you give consent to take part in this study	YES	NO

I have a copy of the information sheet which I can keep.

Signed..... Date.....

Name in Block Letters.....

Signature of independent witness.....Date.....

Name in Block Letters.....

Chapter 1.
EARLY STAGE
(Sessions 1 through 3)

GETTING STARTED

This chapter is not tied to any particular session, but is intended as a guide to clinicians introducing the basic concepts of the cognitive model for depression to their clients.

FOR THE EARLY SESSIONS, GENERAL GOALS ARE:

1. To identify your client's main difficulties or main presenting complaint. Elicit target complaints that can be addressed within the CBT model. If you develop a list of problems work with your client to identify their top priority

2. To elicit client's cooperation to continue with you for up to 18 sessions.

3. To make sure your client understands the basics of the model and to discuss your client's expectations regarding treatment, and how this type of therapy is similar to or different from previous therapy.

4. To engage the client in doing homework as part of treatment.

5. To orient the client to initially keep a weekly activity schedule (WAS) as a record of activities. The WAS is very important in the initial stages of therapy as therapy will be focused on behavioural activation It can also be used later to identify evidence for negative thoughts, concepts, & homework.

6. To gather evidence of negative automatic thoughts, and help your client to see the connections between thoughts, feelings and behaviour. Feed back your understandings but do not attempt to modify negative automatic thoughts (NATs) at this stage unless your client is ready for this.

EARLY SESSION PLANNER: INTRODUCING THE MODEL

1. In the first session, go over client's history as evidenced in the referral letter and on the intake interview. Determine what is the "chief complaint" (what is bringing the person into treatment at this time) and use that to begin to think about and discuss the Target Complaints. This assessment technique should be completed by the end of Session 2 or Session 3.

Describe the Beck cognitive model of depression (using, where possible, examples from your clients own experience). Give examples of the ABC approach; if possible, use material your client has talked about so that it is more personalized. This technique should be completed by the end of Session 2 or Session 3.

PRESENTATION OF CBT THERAPY MODEL TO CLIENT

It is helpful to present the CBT model on a flipchart, as the visual presentation enhances both the understanding of the material and the collaborative process. (Note: this presentation requires a substantial amount of participation from the client.) The following figure is drawn for the client:

THOUGHTS

BEHAVIOURS **FEELINGS**

PHYSIOLOGY

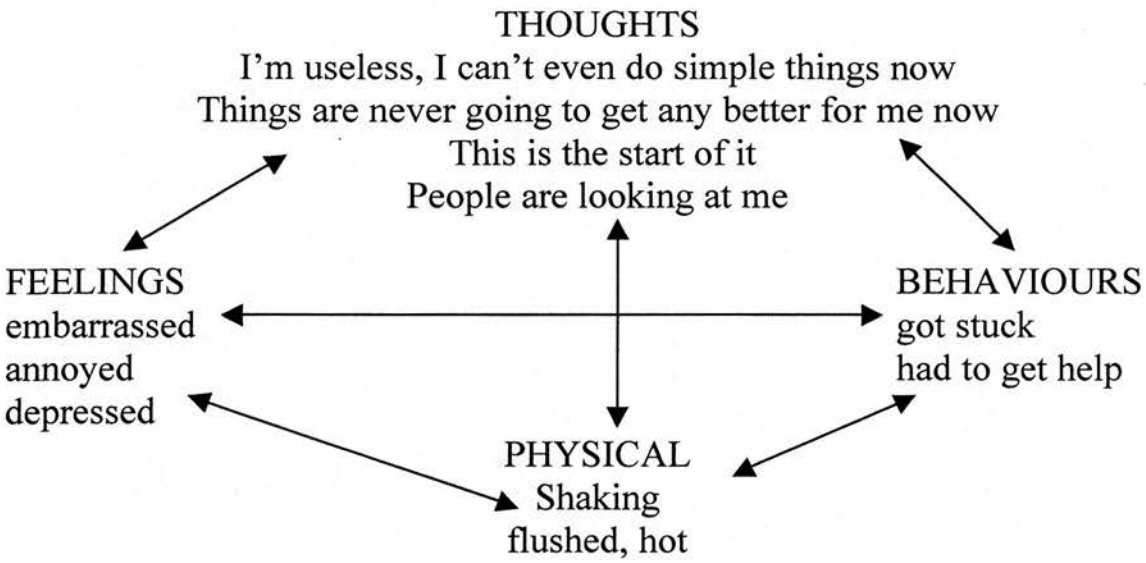
Using the above model, explain to the client: (**NOTE;** therapists are free to use their own method of explaining the CBT model as long as the essential four components are retained) *"I am going to explain to you the basic idea of therapy and how this might be useful for understanding your difficulties. I'd be really interested in whether or not you think this is relevant to your difficulties The way we think about things is related to the way we feel about things that happen to us and to the way we react to these events*" Therapists should draw out the schematic (see below) with the client. A flipchart can be useful here.

NOTE at this point, a good option for therapists is to use an example from your client's own experiences ;, see overleaf.

Case Example: Mr P.

An example is Mr P, a 68 year old retired postal worker, he has a mild form of Parkinson's disease. He tearfully relates an incident which he says shows how 'useless' he is nowadays. He says that recently he went to the local garage to check on his car's tyre pressure. At this time he found it impossible to unscrew the dust caps and although he tried for a long time, he '...eventually had to give in and ask the young lads to do this simple thing for me." He noted that after this incident his mood dropped markedly and he says he lost his confidence. He noted his tremor appeared to get worse after this incident.

SITUATION: experiencing difficulty taking dust caps off at local garage =



The important point here is to let Mr. P. see the connections and the reciprocal nature of these connections. It is important to point out to your client that they can change the way they think about things and the way they behave. If these are so connected to their feelings and to their physical 'makeup' then these elements will change too. A useful thing to do is to explore with the client how they would have managed in the situation they described if they had thought differently.

To repeat, the important thing to get over to your client here is that if their thoughts, feelings, behavioural and physical state are all linked then by changing one of these elements then this has a knock-on effect on other aspects such as their feelings for example.

If you cannot identify an example from your client's description of their ***current*** difficulties you can use the general example below:

"*There are four basic factors that are important for us to understand our response in difficult situations. The first one is physiology. As you know, our physiology and our physical well-being has a great deal to do with how we behave. For example, if you have ever had the flu, you know that it has an effect on you. What was your mood like when you've had the flu" (Prompt: Do you feel happy? Do you feel like you have energy? Is your mood up?)*

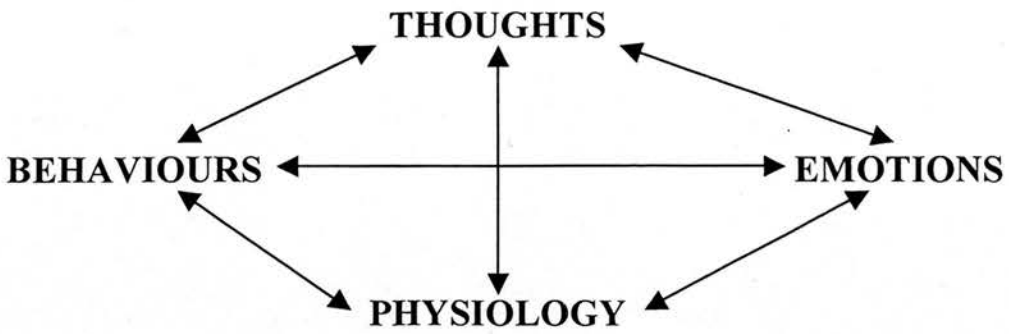
Write the client's response underneath the "emotions" label in the figure (overleaf). Draw a connection between physiology and emotions: Note the bi-directionality of the arrows connecting the elements of the basic cognitive model

THOUGHTS

BEHAVIOURS **FEELINGS**

PHYSIOLOGY

As the presentation continues, you will be making connections between all elements until the figure looks like this:



Continue with presentation:

"Usually, if one has the flu, one feels tired, a bit down, perhaps irritable. So it is clear that your physical health and physiology has something to do with your functioning. What kinds of thoughts might you have when you have the flu?..... (If no response, offer:) Some people with the flu may think, "I'm going to die." "I will never get better." *et cetera.* What did you do when you think these thoughts? (*Prompt: Do you stay home? Do you avoid doing things? Do you need to take care of the household?)* What thoughts did you have in relation to these behaviours? If you laid in bed with the blankets over your head for a day, you would feel how? That's right, you would probably feel (down, sad, blue). Both of these examples show how our behaviour affects how we function. Now, if you were feeling sad and blue, what would happen to your physiology? *(Some psychoeducation may be appropriate here.)* You may have heard how people who are under stress for long periods of time tend to become sick. So it is clear that your behaviour, e.g., giving up pleasant activities, can also effect how you feel as well as your physiology. *(Therapists should continue along similar lines until all four components are interconnected by arrows to each other, representing their interactions).*

EXPLAINING CBT THERAPY WITHIN THIS MODEL

"People usually come to therapy because of this (circle Feelings/Emotions). Usually the person does not feel good emotionally for one reason or another. Unfortunately, it is not possible for me to "reach in" and change how you feel. Similarly, it is not always possible to change your physical state in order to help you feel better. Therefore, we will not be trying to work with your physiology. If we can't work with the emotions directly or your physiology directly, that leaves us with two factors, thoughts and behaviour. This is very good because a CBT therapist can help you change what you do. Also, in therapy you can learn how to change your thinking so that you are not as upset or depressed or nervous about things. Behaviourally, we can help you to learn to build in more pleasant activities, express yourself more clearly, or eliminate unpleasant activities as much as possible. But you may be wondering how we can help you with your thinking.

At this point therapists should suggest that as therapy progresses that the role of a person's thoughts will become more important but for the moment it is important to try to understand when and how a person's mood changes for the worse. At this point in therapy, you will be wanting to help your client become aware of their thinking indirectly by the predominant use of behavioural methods.

Optionally during the early stages you may wish to elaborate upon this, viz; "Let me give you an example. I am going to illustrate the 'A-B-C Model.' A-B-C signifies: Antecedent or Event, Belief, and Emotional Consequence."

Draw the following diagram:

Antecendent	Beliefs	Consequences (emotional)

"Suppose that you are going up on an elevator when suddenly you receive a sharp poke in the ribs. What goes through your mind? *(Client will usually give a mixture of thoughts and feelings. Try to elicit both, while differentiating the two.)* Good! So you think to yourself, "This person is going to mug me," *(write this under the "beliefs" column)* and you feel "scared," *(write this under the "consequences column)* or you might think "what an inconsiderate person," *(write this under the "beliefs" column)* and feel irritated *(the 'C' column).* Now assume that you turn around and you notice the person who poked you is blind. How do you feel now? *(Elicit responses separating B and C column information).* What is different in these two situations? *(Try to get client to explain some variation of I learned something new about the situation.)* Right! You turned around and gained information that you didn't have before in order to have a more comfortable reaction.

"That is a small example of CBT therapy. You will learn various ways to "turn around" your thoughts, assumptions, and perceptions in order to gain new insights and more helpful beliefs that will lead to more helpful emotions."

SUMMARY AND RESPONSE

Encourage your client to summarize their understanding of the cognitive model and the connection between thoughts, feelings and behaviours. It might also be a good idea at this point to investigate any reservations your client have about engaging in therapy (e.g. "it's too much work, you can't teach an old dog new tricks", or "My problems are really due to my laziness rather depression."). It is also important in the early stages of therapy to ask clients how they feel about being depressed (you are investigating your client's view of depression), i.e. do they see this as a sign of weakness, is there evidence for depression about depression.

When discussing your client's understandings and beliefs you should be gentle about correcting erroneous ideas but use this as an opportunity to reinforce what the client did correctly understand. You might wish to gently explore the following questions:

What were the key things they understand about treatment?

What skills does your client possess which will help them?

What assignments might help me practice these skills?

Additional thoughts or questions they have about this material?

These questions are good to use to engage you client in a socratic dialogue about their understandings of therapy.

Client workbook example:

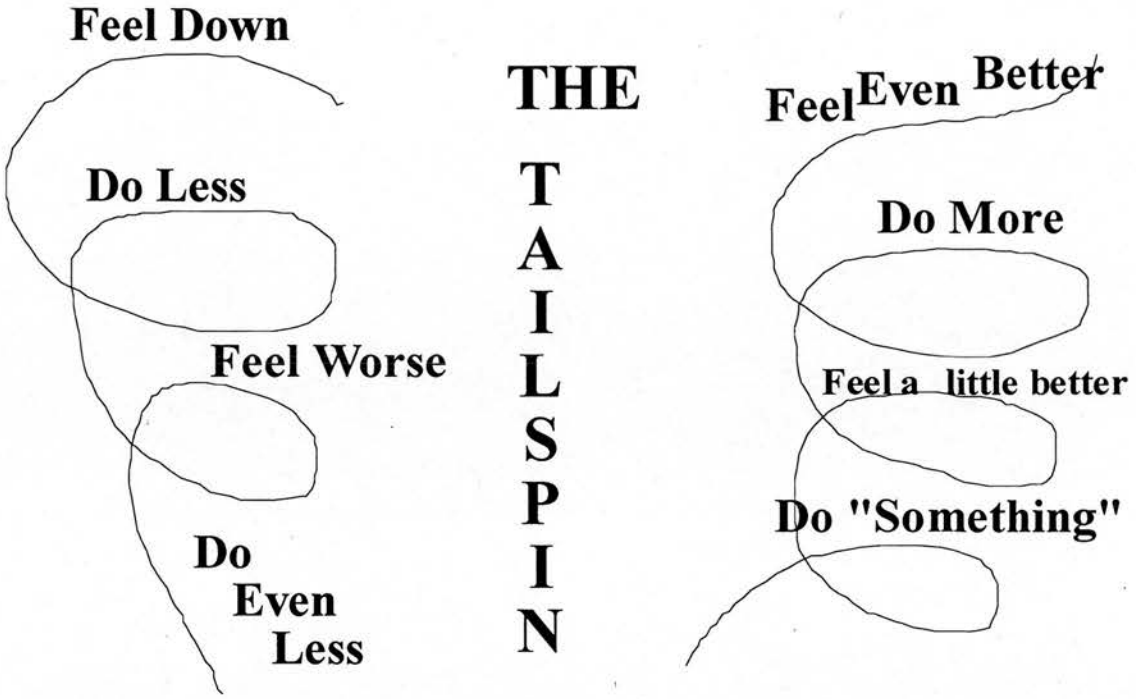
The client manual illustrates the CBT model using the following example:

John is a 66 year old retired, married man who has weekend plans to finish painting his wife's bookcases (behaviour). Unfortunately, he wakes up feeling ill on Saturday morning (health) and is unable to complete the project (behaviour). As a result, he feels angry and anxious about not getting to his work (emotions), believing that he is disappointing his wife (thought). He thinks, "My wife will think that I do not care about helping her decorate the study." This belief raises his anxiety (emotion) as well as his frustration about not feeling up to par. This makes it even harder for John to figure out how to face the day, and consequently he stays in bed (behaviour), which in turn only serves to raise his anxiety and strengthens his negative thoughts about his wife's reaction.

If the client has difficulty with these concepts, pages 3 - 4 of the workbook has worksheet reviewing this model and asking the client to fill out an example of their own.

Downward Spiral

Keep in mind an important idea in CBT is that events in these four components have a notable influence on one another, and that this influence is reciprocal in nature. Thus, a negative thought stemming from an unpleasant event can affect activities or emotions, which in turn can affect thoughts, etc. In some instances these components can start a downward spiral of negative changes that can throw you into a tailspin, leading to depression or an anxiety disorder. See the figure below:



This illustration shows that "giving in" to the "slowed down" feeling that often comes with depression leads to a downward spiral -- do less -- feel worse -- do even less, etc. You will learn ways of stopping a tailspin and also reversing one. Notice that the figure on the right shows you that you can "pull out" of a tailspin.

It is important to use the weekly activity schedule in the early stages of therapy to counteract this negative cycle.

DISCUSSING EXPECTATIONS OF CBT WITH CLIENTS:

It is important to explore your client's past therapy experiences and clarify how CBT therapy is different from others. An explanation of the following concepts are often necessary:

a. The collaborative relationship. The heart and soul of CBT therapy is the formation of the collaborative relationship between the client and the therapist. As this element is explained to the client, it is helpful to discuss with clients' past therapy experiences by comparing and contrasting those experiences with CBT therapy. Explain that the collaborative relationship means that both the client and the therapist take an active role in understanding the problems that brought the client to therapy, defining goals, working to achieve goals, and working through the termination.

b. Goals for therapy. The outlining of specific goals for therapy makes tracking progress a measurable task. This process is reviewed in a few pages.

c. Homework. We cannot put enough emphasis on the importance of practicing new skills in between each session. Practice is one of the best ways we know to make the therapy skills a routine part of daily life. Many clients are not comfortable with the term "**homework.**" So, if need be, find a term for it that will enhance compliance from the client. Homework should be given at the end of every session.

SUGGESTIONS FOR EARLY SESSION HOMEWORK TOPICS

In the early stages of therapy it is essential to engage your client in understanding the important role homework plays in their treatment plan. After your first sessions, a good starting point is to get your client to complete a weekly activity schedule. This gives you a way of assessing how much activity they are engaging in. You can use the WAS to identify avoidance behaviour. You can also identify aversive experiences that may occur during the course of the week. It is also important to assess how much dutiful rather than enjoyable activity is involved in your client's week. The WAS serves a number of useful functions early on in therapy:

- It orients your client to carrying out work outwith the session
- It can often alert your client to the potential benefits of monitoring as a way of finding out information they had access to but were not making use of.
- It can help identify good and bad changes as they occur in-between sessions

It is important that you explicitly discuss the rationale for each homework task as you agree upon it with your client.

Another good piece of homework at the start of therapy is to ask your client to read 'Coping with Depression' by Beck & Greenberg (1974).

SOMETIMES HOMEWORK IS HARD TO DO.

Many circumstances make it difficult for clients to complete homework. For example, time constraints, a difficult assignment, or fears that they are doing it "wrong" commonly interfere with completing homework. Some people may feel resentful of a therapist "telling them what to do," or sometimes people think that the homework is silly, or useless. Avoiding homework can seriously interfere with progress, so it is helpful to engage in a dialogue around a homework task and finding strategies to enhance compliance. **It is important that you check your client's understanding of the relevance of the homework task that has been agreed.** *Good questions to ask your client when discussing homework are "what is the point of doing this?, what can you potentially gain from attempting this task?"* **Obviously it is important that the therapist has a clear and explicit rationale for each homework task.**

a. Concerns regarding the "right way vs. the wrong way". There is no way to do homework wrong the first time. We use the analogy of learning to ride a bicycle for the first time. "Think about when you learned to ride a bicycle. Did you ride it "wrong" the first time, or did it just take a little practice? You will not know if the homework is helpful unless you try it. Just like your first bike ride, get on and start pedaling!"

b. Time constraints. If clients report that they are "too busy" to do the homework, work with them to plan a time and manage the distractions around the assignment.

GUIDELINES FOR HOMEWORK ASSIGNMENTS

Homework should arise from discussions within the session (therefore you may actually decide upon a homework task midway through the session). You might say to your client, "what do you think would be a good way to take our discussion further?" as a way of collaboratively agreeing upon a homework task.

Homework should be personally important and relevant to the individual. It should take topics further. It is central to the presenting problems

Homework should be manageable and time-limited. Make assignments small, especially at first. Do not ask person to do something you would be unwilling to do yourself

Homework should be specific. You and your client should be clear about what is to be done and the reason for agreeing upon this. You might ask your client their understanding about this. "What is the reason for doing this, what do you think you might gain?"

Homework should be realistic. You might try to help person problem solve in advance. "Are there any problems you foresee which might make this task difficult for you to complete?"

Homework is a learning process. It is not necessary that the person is required to do everything successfully. The purpose of homework is to find out more information. If things do not work out as predicted then a lot can be learned form this experience. Try to set tasks as a 'no-lose' situation. Even if the person has not completed their homework this can be used as a fruitful topic for discussion within session. The reasons for not doing something can be very useful in providing further information for your formulation.

Mutual Feedback

Allow about five (5) minutes for mutual feedback at the end of all subsequent sessions. Model for the client by giving your own feedback as to how you think the session went. Ask client for both negative and positive feedback. Encourage honesty and explain that this is important information to help you in adjusting the pacing, tone, and content of future sessions.

Chapter 2: SESSIONS 1-3:

Standard Structure of Sessions

1. Probe question. Before starting the session, ask your client a probe question to determine how they have been managing since you saw them last. This question, such as how have things been since our last meeting can help when it comes to setting the session's agenda.

2. Set an agenda It is an essential part of the structure of cognitive therapy sessions to **set an agenda at the start of every session**. It is important to do this quite early on in treatment so that bad habits of rambling, talking, or unstructured use of time do not get established; they are harder to break once established than to prevent from occurring! Remember that your client will quickly develop expectations about the structure of sessions. You can set an agenda by saying that this is what you are doing in order to make the best use of the time available.

It is wise in the early sessions for the therapist to take most of the responsibility for setting what you think will be a useful, productive agenda. Besides homework review, you might add a particular idea you've been thinking about that seems pertinent, such as gathering more information or history about a certain event or period in the client's life, or finding out more about the family, living, or job situations, etc. ALWAYS ask the client to add to the agenda; e.g what does he/she want to talk about today? or ask, "As you were coming along here today, was there anything you had in your mind to discuss?" Add to the list and then prioritize (later on, it's good to

add projected amounts of time to each item so that the session moves along and everything gets at least some time). Once the agenda has been agreed, ask your client, "*If we talk about these things today will this cover your major concerns, will it mean we are talking about the most important things that are happening for you right now*".

3. Reviewing homework: The first item on the agenda should always be the homework review. If this is not done, the client will soon realize that homework is not that important, despite what you might say, therefore compliance will be minimised. A sizable body of research suggests that depressed patients who do homework regularly obtain greater benefit from therapy and have less difficulty generalizing what is learned in therapy to the rest of their lives. Also, homework is a skill that the person can use after therapy is over. If homework has not been complied with it is very important to discuss this.

The therapist can ask the client if the task set seemed un-connected to their current difficulties. You will want to investigate other possible reasons for non-compliance with homework such as a lack of clarity of assignment; lack of time on client's part; lack of motivation; no real belief in the model, etc. You need to elicit reasons and respond within a CBT framework; e.g., this is an experiment, it would be good for you to collect data about whether or not doing homework is helpful rather than to just assume it isn't, etc.

4. Target Complaints and Goals "Target Complaints" refer to delineations of what situations are troublesome, so that specific measurable behavioral goals for change can be set. We recommend the identification of three target complaints for the course of therapy. The remainder of the session before homework, summary, and feedback will be devoted to the following components of identifying target complaints and goal setting.

    1. Identify the target complaint.
    2. In what situations does this occur?
    3. What does the client attribute to the cause of this difficulty?
    4. Has this problem come up before?
    5. What strategies have been used in the past to cope with this problem?
    6. client rates the severity of this problem from 1 (least severe) to 10 (most severe).

All six components are explored for each problem. As you discuss this, your client can complete pages 16 - 18 in the workbook. In the workbook, the client sees the following case example:

Mabel is a 77 year old woman who states that she has had bouts of depression all her life. Mabel lives with her husband of 51 years, and they have three grown children who all live nearby with their families. Mabel reports that she has virtually no contact with her children stating "they blame me for everything and believe that I was a bad mother." She also reports that she has a difficult relationship with her husband, especially when they disagree about their children's decisions.

Mabel explains that this time her depression began three months ago when she stopped volunteering at the local children's hospital. Mabel states that it was her decision to end this activity when she discovered that her co-volunteers did not have the same values that she held. Mabel was able to identify 3 areas that she would like to change:

<u>Problem #1</u>: I would like to find more things to do with my day.
<u>Problem #2</u>: I would like to be completely free of depression.
<u>Problem #3</u>: I would like to communicate better with my husband and children.

5. <u>Translating target complaints into goals.</u> The difference between a target complaint and a goal is that a goal is a well elaborated plan of change (whether focusing on behaviors or beliefs) that is: important, time-limited, specific, realistic, positive, and measurable. Each of these properties are defined below and illustrated through the case example's (Mabel) desire to increase time for herself and the things she enjoys.

Important: Your client's goal must be a priority for them or else they will not have the motivation to work on it.

Mabel's goal was very important to her. She believed that unless she started treating herself better she would not be an active member of her family.

Time-limited: Cognitive-behavioral therapy is a short-term treatment, therefore, the goals you set must be manageable within the time allowed.

The therapist explained to Mabel that brief, cognitive-behavioural therapy has been shown to be effective in helping people organize their time and introduce pleasant activities.

Specific: If a goal is too complicated, or depends on too many components and regulations in order to be met, it is not a good recipe for success. It is always recommended that goals be straightforward and be targeted to a definite area of your client's life.

Mabel's desire to introduce new hobbies or pick up old ones is a very specific goal.

Realistic: A goal must be something that you *can* do independently.

Mabel is the only one who will be ultimately responsible for making these changes. She will not be able (nor does she need) to rely on others to either give her time during the day or provide her with hobbies.

Positive: Often, when people are depressed, they phrase their needs in terms of losses or negatives. Stating your goal with positive language will help you begin to understand how you can be in control of the changes that you want to make.

Mabel has presented a negative state of being such as "not having any time for myself," and she has restated it in terms of what she wants to gain and how she wants to take an active role in these changes.

Measurable: In order for you to recognize changes in your goals, it is important that the stated goal can be assigned a value along the 10-point scale to be used later in comparing the status of your complaint at the

beginning of treatment to different times throughout therapy. The same rating scale will be provided at these times. Aside from measuring change, the comparison of these values can initiate the discussion between you and your therapist about which strategies have been helpful to making change, or if little change has been seen, what new strategies can be introduced to enhance improvement.

Remember that Mabel rated the strength of her distress over this issue as an "8," which is quite high. This value will be compared to her perceptions of this issue at both the midpoint and the end of therapy.

The case example continues with an explanation of how a target complaint becomes a specifically stated goal:

Goal # 1

To increase pleasant activities in my day.

1. Is your goal:

Important to you?	Specific?	Positive?
Time-limited?	Realistic?	Measurable?

2. How could you or someone else determine whether this goal has been met or not at the end of treatment? Please specify some concrete behaviors or concrete events that might be used as criteria that the goal has been met.

a. If treatment is a success in regard to this goal, I will probably:

Have consistent, scheduled time for both my household responsibilities and fun activities. I will probably feel less depressed and less trapped in my home.

b. If treatment is partially successful, I will probably:

Have inconsistent (less planned) time for myself. I will probably still have strong moments of sadness about not being in control of my day.

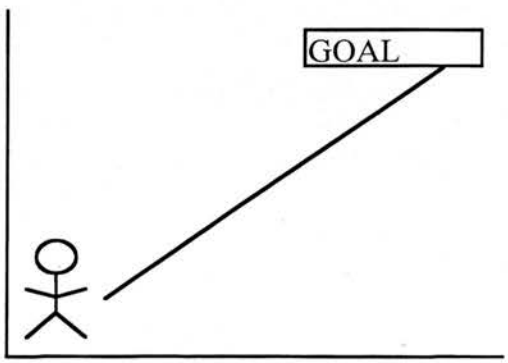
c. If the goal is not met at all, I will probably:

Nothing will change, and I will still be depressed.

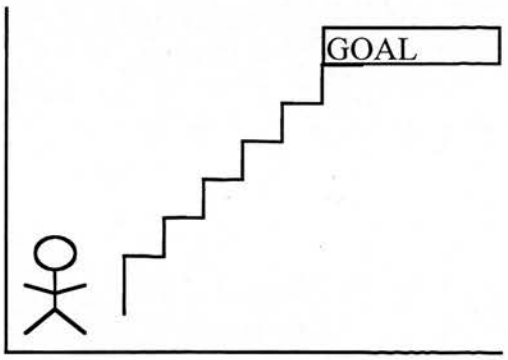
Pages 22 - 24 in the client's workbook are blank worksheets outlining the specific goal and the questions relating to the goal in the above example.

6. Explain how progress is made: By Successive Approximation.

Clients often expect that change happens immediately once the process of therapy begins. See the figure below:



It is important to discuss the process of change and help the client to avoid thinking in extremes. Help clients to avoid thinking that if goals are not reached quickly, it does not mean that "nothing" was accomplished. In addition, progress on the goals we set rarely occurs at a steady pace, or in a continuous direction, like smooth curve:



Rather, it is difficult to learn a new way of thinking and new behaviors that we have seldom or never tried out before. And, some days making the effort and showing progress is easier than others. Just as importantly, encourage clients to recognize and then reward themselves for each step made toward achieving the goal. So when reviewing the progress of goals, remember most change happens with setbacks in between, and looks more like the "saw toothed" curve below:

Encourage clients to evaluate the overall process, not just compare the result of one week against the result of the previous week.

7. Set up new homework assignment. For the first few sessions you are likely to make extensive use of the Weekly Activity Schedule (WAS). The first time you are setting the WAS it is a good idea to get your client to complete the form without ratings for mastery (M) or pleasure (P). Later you may wish to introduce M & P ratings as a way of introducing the connecting between mood and activity level. They could continue on the theme started in session (that often makes sense and has face-validity for the client), or you can just ask them to record once a day or each night about any negative emotions experienced during the day and associated thoughts. Try to set the specific time that the client should do their homework, since increased structure and collaboration will improve the probability of the client completing the task. Again, the homework is ideally related to a theme discussed during the session or to a client's target complaint. It is important to state clearly that the client bring the WAS to each session, as it will provide a focus to the next session.

8. Summary of session. The importance of summaries was discussed in the previous chapter. Page 27 of the client workbook contains the summary sheet with the following questions:

What were the key points brought up in this chapter?
What skills did I learn?
What assignments might help me practice these skills?

9. Mutual feedback: Feedback in session is designed to encourage your client to discuss what was helpful about the session and what was not helpful. You also want to be able to give selective praise and positive reinforcement for the client's compliance with the session's focus. Also, problems in the relationship can be discussed (e.g., I don't think we are understanding each other as well as I'd like us to; let's talk about what seems to be the problem in communication between us). It is very important to attend to any process-issues that could interfere with the successful implementation of CBT therapy, but we generally reserve discussion of this for the end of the session.

10. Repeat time and date of next appointment. Early on, It is good practise to set up the full 16-20 session schedule with your client if at all possible, so that times and days of the week become "regular" for you both. Laying out all the following planned sessions can be helpful too in reassuring your client that therapy will go on, even if client is not responding yet or doesn't know how helpful it will be, etc. WE STRONGLY RECOMMEND DOING THIS AS A REGULAR PRACTICE.

Chapter 3.

Doing Tools: Increasing Pleasant Events

The importance of engaging in pleasant events

One popular theory about the causes of depression stresses the functional relationship between depression and everyday life events. This is the basis for the behavioural model for treating depression, specifically;

> A low rate of response contingent positive reinforcement in major areas of life or in valued activities and goals and/or a high rate of aversive experiences leads to dysphoria and a reduction in behaviour which results in depression.

Such that:

- There is a causal relationship between the low rate of, what is termed, response-contigent positive reinforcement and feelings of dysphoria. (A substantial portion of the most salient postive reinforcers in the adult's world are interpersonal in nature).
- Depressive behaviours are maintained partly by the social environment through the provision of reinforcement contingencies in the form of initial sympathy, interest and expressed concern
- Deficiencies in social skills function as important antecedents to the low rate of positive reinforcement.

When someone becomes depressed they tend to cut back on activities and hobbies and hence cut themselves off from things that give them enjoyment. As a person's mood level drops further, a vicious cycle develops (i.e. lower mood, increased apathy and reduced motivation, further isolation and reduction in pleasurable activities). In addition, at first, carers, relatives, friends, etc., are quite concerned and give the person a lot of attention

(negative reinforcement). The person then becomes increasingly aversive to be with and the depressed person tends to become more isolated.

The theory reasons that when we encounter one event or maybe a series of life events that reduces the level of pleasure we experience our mood is lowered. Remember the downward spiral presented earlier in this manual? It can apply here as well. When mood is lowered, then level of activity also decreases. When level of activity is reduced, then there is even less likelihood to engage in activities that would be pleasurable. This tends to lower mood even further, which in turn continues to reduce our activity level, and so on until we are in a vicious tailspin that leads to a prolonged mood disturbance and the development of numerous other symptoms of depression. BASICALLY THERE IS A LOOP BETWEEN A PERSON BECOMING DEPRESSED, CHANGES IN ACTIVITY LEVEL AND THE REACTIONS OF OTHERS TO THAT PERSON'S BEHAVIOUR. We have found that if we can convince depressed clients to increase their level of pleasant activities on a daily basis, then their mood is improved and their symptoms of depression are reduced. We have found that if this problem is approached systematically, depressed individuals frequently can and do develop the skill of increasing their level of pleasant activities in order to offset negative life events and the resulting lowering of mood.

Creating an activity level baseline

You need to ensure that the person you work with completes a Weekly Activity Schedule (WAS) as a baseline.

e.g.

Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8.00	read paper	read paper	papers				
9.00	housework	housework	walked dog				
10.00	watched tv	watched tv	shopping				
11.00	read paper	read paper	golfing				
12.00	lunch	lunch	lunch				
1.00	knitted	knitted	watched tv				
2.00	watched tv	watched tv	knitted				

The WAS gives you an idea of the person's activity. Importantly it gives you a measure of how much or how little they are doing. You can also use it in later sessions to get the person to record mastery and pleasure. You can see whether the person is either doing 'too much' or 'too little'. Later by adding mastery and pleasure ratings you will be able to derive mood fluctuations during a person's recording period.

Mastery is a sense of achievement gained from doing something.

Pleasure is a indication of enjoyment gained from doing something.

At first it is important to help the person identify that their mood and activity level are linked by using the WAS. Once the person makes the connection between the effect of not doing things and their mood level you need to help them to *identify potential pleasant events*. Identifying potentially pleasant events (PEs) means finding activities that people like to do, then encouraging people to do them so they feel better.

Pleasant events don't need to be big events like going on holiday or decorating your house. In fact many people have small pleasant events that they take for granted like reading the newspaper, or having a leisurely lunch. Working in the garden or washing the car can be a pleasant event for people, as can talking on the phone to friends. ***Anything that a person likes to do is a pleasant event.***

When people become depressed or anxious and worried they tend to cut back on doing the things they used to enjoy and take pleasure from. The answer is to help the person plan to do something they enjoy at least once a day. Just putting in a few extra pleasant events in a person's week can make a big difference to the quality of their lives and to the quality of their mood. Analyse your client's completed WAS; were there a few events they could have added in to improve their week?

There are a number of guidelines to helping a person identify potentially pleasant events.

- **The PE must be realistic**

The person may enjoy travel and holidays but realistically people can't do this everyday. In this case it might be more realistic to help the person plan short bus trips into town by the scenic route if possible

- **Choose a PE which can be increased.**

If you choose an event which is already occurring on many days you will not neccessarily be able to increase the number of times this event occurs. It is much better to help the person focus on building up hobbies or behaviours which may have decreased recently. ***By increasing a behaviour you have the potential to impact positively upon a person's mood.***

- **Choose only the TOP TEN events for your list of pleasant events.**

Help the person identify ten pleasant events to put on their list. Ask the person to put the events in order with the most enjoyable event at the top of the list. Remember that the event at the top of the list may not be the most ideal event but the most pleasant event that the person can do on a regular basis. ***Allow the person to change the list if they discover more events as you go along.***

Creating a List of Pleasant Events

Ask your client to list the things they most enjoy doing in the table below. This is most productively done collaboratively during the session. It however also be set as a homework task. Get the person to list things they would enjoy doing even if they are not currently engaging in them. If a person cannot identify TEN items get them to list as many as they can. Listen for any new ideas you may add.

You may find it useful to use the completed WAS to identify things which gave the person some enjoyment from their previous week. A good tip is to ask the person to complete a WAS with ratings of their activities for mastery and pleasure (M & P). You can use a seven point scale for this purpose; with 0 representing no pleasure, and 7 representing maximum enjoyment. It is best if you ask the person to complete the WAS without ratings for M & P the first time they do it, as this avoids confusion. Once the person is able to complete a WAS, after a few weeks you can add in ratings for M & P.

Top Ten list of pleasant events (activities) that I enjoy:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Tracking your List of Pleasant Events

Once you have helped the person identify their TOP TEN list to help raise their mood you will need to record the occurrence of these events. Each day ask the person to complete the WAS as before but ask them to mark the occurrence of events from their TOP TEN. You may use the WAS to schedule in times when the person ought to do something from their top ten.

Monitoring Mood

The next step is to learn to monitor mood more carefully, in order to notice subtle mood changes. Many clients will report that their mood is "just so-so," without noticing the gradations in between. This example appears on page 63 in the client workbook.

Susan is a 67 year old married woman who lives with her husband, and granddaughter and 2 year old great-grandson. Her granddaughter has been living in the home for several months while she is attending graduate school. Her granddaughter's arrival coincided with Susan's partial retirement from her career as a florist. She decided to gradually stop working in order to help take care of the 2 year old boy while her granddaughter is in class. Lately, Susan has become quite depressed about the amount of her household tasks as well as the fact that baby-sitting has slowly cut off her social activities. On one particular day, Susan finds that she has the day to herself when her husband is away on business and her granddaughter is visiting her parents during a school break. On this day, she gets up preparing for a full day out in her garden. She feels refreshed and reasonably happy. As she starts to work she suddenly realizes that she does not have several supplies she needs for the tasks she wishes to complete. Slightly frustrated, she decides to go out and pick up these supplies. During these errands she gets stuck in a long traffic jam resulting from construction on a major thoroughfare. In the nursery she feels rushed and annoyed when a young salesperson is rude to her when she asks a question regarding some supplies. As a result, she doesn't get everything that is on her list, which causes her to return to the store; thus spending more time on this unplanned errand. The traffic is once again terrible on the way home. Susan plans to immediately return to her garden upon getting in the house, but finds an upsetting phone message on her machine from her daughter who is stranded by her broken-down car. Susan gets her daughter, takes her home, and is irritated when her daughter does not acknowledge that she has disrupted the day that Susan planned for herself. Susan decides to go directly to the backyard in order to salvage whatever daylight hours remain. Susan works in her garden for 2 hours. During that time, she is able to feel less tense from the interruption in her plans, but she still believes that she had lost all control over that day, and she feels helpless in ever being able to carve out more personal time for herself.

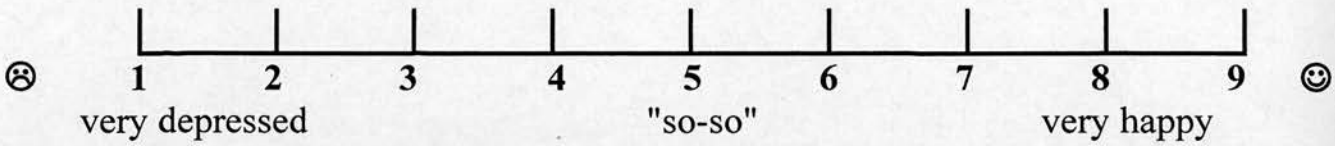
Notice that Susan started the day feeling happy, relaxed, and focused on a task for herself. By the end of the day she was feeling sad, overwhelmed and perhaps was getting the impression that she had little control over events in her life. Like for most of us, this was "one of those days" for Susan where nothing seemed to go right, and it's certainly understandable that she might be under the weather. Susan's dilemma was complicated, however, by the fact that she couldn't see how the specific events of the day had impacted on her mood. If Susan had been in the habit of paying closer attention to her mood variations, she would have seen the relationship between the different events during the day and the changes in her mood she could then plan activities or strategies to enhance her mood or possibly prevent a dramatically lowered mood.

Often, when clients become overwhelmed by their mood, and they are unaware that they may be experiencing several different moods during the day, we ask them to rate their mood at several key points during the day. If Susan had rated her mood upon awakening, at lunch time, at dinner time, and then at bedtime she would get a better sense of how her mood fluctuates and what events were related to these moods. In order to expand Susan's knowledge of the relationship between her mood and her behaviors, she

completed a chart where she monitored her mood at different points during the day and identified the situations that occurred at the point of these ratings.

DAILY MOOD RATING FORM

Please rate your mood for each day, i.e., how good or bad you felt, using the nine-point scale shown below. If you felt good, put a high number on the chart below. If you felt "so-so," mark a 5. And if you felt low or depressed mark a lower number.



2. On the two lines next to your mood rating for each day, please briefly give two major reasons that might have had an influence on your feelings. Try to be as specific as possible.

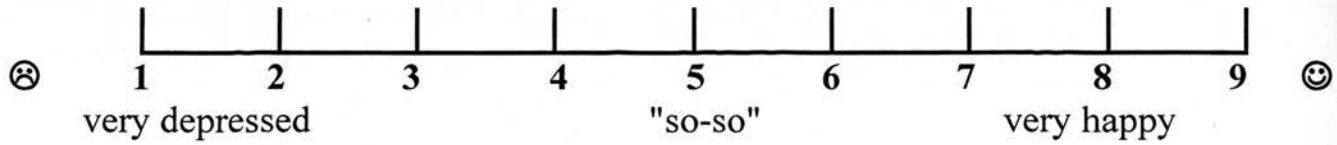
Time of Day	Mood Score	Reasons why I felt this way:
morning	**9**	I woke up refreshed and excited about my garden.
lunchtime	**3**	I never ate lunch due to my nursery mishap and rescuing my daughter. I was hurt that my daughter was unsympathetic to having interrupted my day.
dinner	**5**	I felt a little better after working on the garden, but I am still quite disappointed about all of the time that I lost.
bedtime	**3**	I rarely get time for myself. My personal projects will forever go unfinished.
Average for the Day:	**5**	I constantly take care of others, and I rarely put myself first.

Notice the relationship between Susan's mood and the events that she experienced. Here, Susan's low mood was related to planned personal time gone awry as well as a lack of acknowledgment from her daughter that she deserves time alone. In fact, her lowest mood scores occurred when she believed that trying to do what she wanted was a lost cause. Yet, Susan did recognize that her mood elevated slightly as she finally engaged in her gardening. On the next page is a blank daily mood rating form that you can copy for use with your clients. Encourage your client to pay attention to the events that surround these moods and record those events that they believe contributed to their mood score.

DAILY MOOD RATING FORM

Dates: From _____ to _____

Please rate your mood for each day, i.e., how good or bad you felt, using the nine-point scale shown below. If you felt good, put a high number on the chart below. If you felt "so-so," mark a 5. And if you felt low or depressed mark a lower number.



very depressed "so-so" very happy

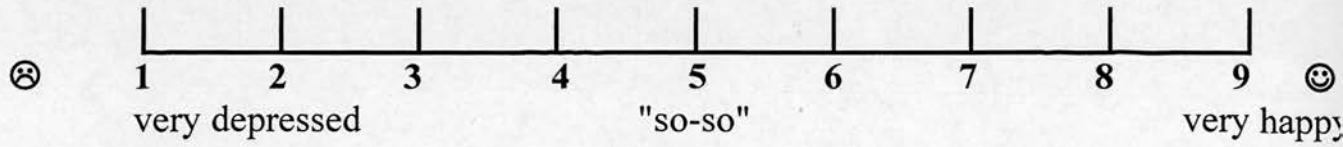
On the two lines next to your mood rating for each day, please briefly give two major reasons that might have had an influence on your feelings. Try to be as specific as possible.

Time of Day	**Mood Score**	**Reasons why I felt this way:**
Early Morning		
Noon		
Dinner		
Bedtime		
Average Daily Score:		

DAILY MOOD RATING FORM

Dates: From _____ to _____

Please rate your mood for each day, i.e., how good or bad you felt, using the nine-point scale shown below. If you felt good, put a high number on the chart below. If you felt "so-so," mark a 5. And if you felt low or depressed mark a lower number.



On the two lines next to your mood rating for each day, please briefly give two major reasons that might have had an influence on your feelings. Try to be as specific as possible.

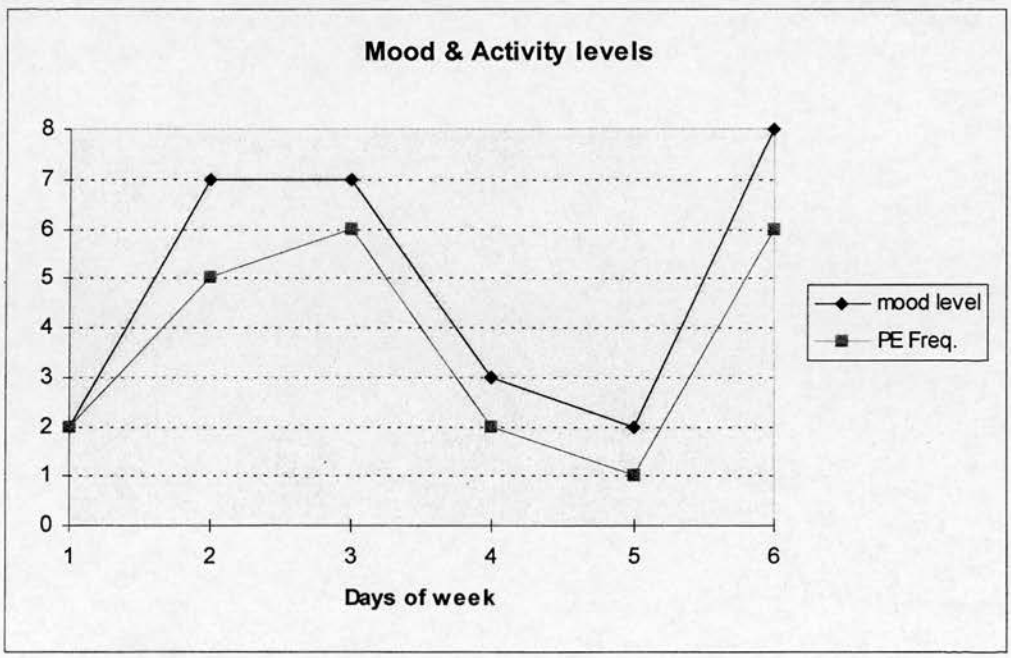
DATE:	MOOD SCORE:	WHY I THINK I FELT THIS WAY:
2/18	5	1. I did a few pleasant events. 2. My friends canceled lunch.
2/19	6	1. I spent the afternoon with an old friend. 2. I started a new novel.
2/20	6	1. I took myself out to lunch and went shopping. 2. I listened to my Ella Fitzgerald CD.
2/21	2	1. My great-grandson was a "holy-terror" and would not take a nap. 2. I had no time to myself.
2/22	6	1. I spent the day alone. 2. I spent time reading after I cleaned the house.
2/23	8	1. My granddaughter had no class and took the baby out for the day. 2. I played with my friends all day.

Making the connection between mood level and PE

The purpose of this exercise is to let people see explicitly, using their own experiences, the connection between activity and mood.

The final step in helping your client/patient to increase their activity levels is getting them to see that as they take part in doing more pleasant activities, this has a positive effect on their mood. The easiest and most efficient way of doing this is to collate the information you have from the WAS or by using *Pleasant Events Tracking Form* and combing this information with that from the *Mood Monitoring Form.*

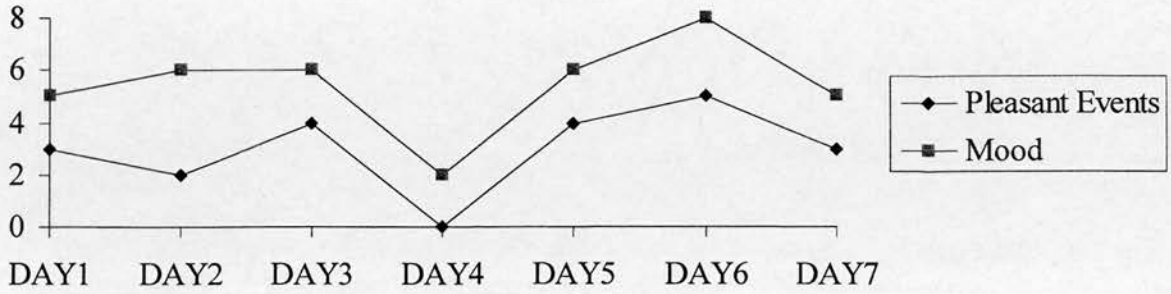
To chart this information, make a graph by drawing two axes. On the vertical axis, you can plot numbers from 0 -9 (this is the same scale from the MMF). On the horizontal axis, you can plot the days of the week. You will need to have two coloured pens with you. Use one colour (or symbol) for mood level. Use another colour (or another symbol) for number of times person has taken part in PE. You can plot these on a graph.



The chart above can show that mood level and activity level are connected.

This can be a very powerful technique to use with people.

A graph of Susan's Pleasant Events and Mood Rating was done to illustrate the relationship between the pleasant activities and mood.



Look carefully at this graph. For the most part, as Susan's pleasant events increased, her mood increased. This suggests that in general, she could expect to feel better on days when she had more time for herself. Take a closer look at "day 2" on this graph. Notice that there were only 2 pleasant events performed, but the mood rating is a 6. Sometimes certain pleasant activities boost mood more than others. For Susan, visiting with her friends after being isolated for such a long time was so important that for this day, it was largely responsible for increasing her mood from the previous day. Therefore, it is not only important for clients to pay attention to the number of pleasant activities they do, but also the type of activity in order to enhance mood.

Identifying Obstacles to Engaging in Pleasant Events

It is not uncommon for depressed people to say they cannot do this. It is too difficult or they do not see what good it will do them. It is useful to have a discussion (using the socratic method of questioning) to identify how they might benefit from doing these activities. You may want to construct a pros and cons form to help them identify what they will gain from doing this. Try to get the person to try it and see what happens. Set this up as a 'no lose experiment'. If the person does it they will see whether it is of benefit. If they don't, you will still have gained information as you can work out with the person what the difficulties were. Perhaps the task was set at too high a level, perhaps the aims were unrealistic, etc. By agreeing to try, you and your client are a step forward from before. This is a no-lose situation and this should be emphasised as such to your client.

It might be useful to identify obstacles in advance. This gives you a chance to trouble-shoot. You might also want to check the person's understanding of what is required of them.

Personal obstacle that could keep me from increasing my pleasant events

Is the obstacle an unhelpful thought, a feeling or maybe a physical barrier?

How relevant to my problem is this task?

You are now ready to start introducing the idea of thoughts monitoring and challenging

Section II: Tool Box
Chapter 4: Thinking Tools
We can change the way we think

An important part of cognitive-behavioural therapy is knowing that unhelpful thoughts can create negative emotions. Yet, this process happens so quickly that clients are often unaware that thoughts occur between a stressful event and uncomfortable emotions. Thus, it becomes important to teach your clients to slow down their thought processes in order to identify the thoughts in between the stressful event and the intense negative feelings that they are experiencing. Teach your clients to use an Unhelpful Thought Diary (UTD) to slow down their thoughts and to keep track of *what* they are thinking once they have noticed a strong emotional reaction.

Dysfunctional Thought Record/Unhelpful Thought Diary

Research has demonstrated that clients who are more skilled at completing dysfunctional thought records (DTR) are more likely to benefit from treatment for depression. Compared to clients who were less skilled at completing thought diaries, skilled clients were less depressed at six months follow-up. This result suggests that being able to complete a thought record may protect people from relapse as it gives clients a skill and a strategy to use in order to manage their mood. The criteria suggested for skilful use of DTRs is as follows:

- ***Does the client clearly describe a specific situation?***
- ***Does the client specify explicitly their emotions in the situation?***
- ***Does the client list verbatim their negative automatic thoughts?***
- ***Does the client list their rational alternative responses?***
- ***Does the client re-rate their mood state after completing the DTR?***

These criteria suggest the steps that therapists ought to ensure clients are able to develop in their attempts at challenging their negative automatic thoughts. Before going further, stop and think for a moment about what you know about negative automatic thoughts. It is useful to be able to explain in a concise way what negative automatic thoughts are.

Negative Automatic Thoughts (NATs) often share certain characteristics, such as:

They are plausible and believable; To your client they appear realistic and appear to cover all the facts

They are experienced as spontaneous; They pop into person's mind unbidden

They are often couched in the form of should, must, ought; person is chastising self or indicates guilt

They often appear in shorthand; Alert your client to look out for telegraphic phrases such as "I can't stand it", "never good enough" "can do better"

They tend to 'awfulize'; catastrophising and blowing things out of proportion

They are relatively idiosyncratic; reflects person's own individual way of seeing things, reflects personal exp.

They are persistent and self-perpetuating; To your client negative thoughts often appear plausible and are therefore very difficult to dismiss

They reflect inconsistency in understanding attitudes: person is much harder on themselves than they would be to others

They reflect habitual themes; person is preoccupied by certain fears or feelings of inadequacy

They are learned; reflect person's upbringing and background

Part I: Identifying Unhelpful Thoughts

Below is an example of a Unhelpful thought form. It has been deliberately left blank for you to copy and use.

Identifying Automatic Thoughts

Situation Where were you? What were you doing? Who else was there?	*Automatic Thoughts* What thought went through your mind when your mood changed? What did you say to yourself?	*Feelings* What emotion did you feel (describe in one word) How bad would you rate your mood? (0-100%)

Please remember to bring this form with you for your next appointment. Thank you

Initially, recording three pieces of information on this thought form will help clients to practice noticing and monitoring the thoughts that immediately follow a stressful event. Educate your client to give you:

a.) a brief description of the situation in which mood changed negatively

b.) Any automatic thoughts they had in connection with this event

c.) The emotions that they experienced as a result

Encourage clients that they cannot make any changes in their mood or thoughts unless they know what to change! The following is the example from the client workbook.

Jane, a caregiver, plans to go to a support group at 1:00. At 12:30 she finds that her father, who has Alzheimer's disease, becomes agitated and soils himself. The woman she pays to stay with her father for a few hours each day has not arrived.

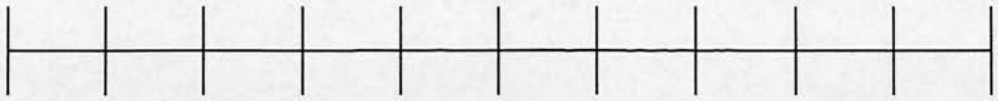
Jane's Unhelpful Thought Diary

Situation	Automatic Thoughts	Emotions/Feelings
Father soils himself before I am ready to leave. My paid caregiver has not arrived yet.	**1. He would have to do this NOW, he's doing it on purpose.** **2. Why Me?** **3. She (the paid caregiver) is not coming!** **4. I NEVER get to do things for myself.**	**frustrated** **angry** **hopeless**

The strength of unhelpful thoughts

In order for clients to understand the impact that unhelpful thoughts have on their mood, it is helpful to assign some value or rating to these thoughts to indicate how strongly your client believes in each one. The rating exercise can help them identify which thoughts have the strongest emotional impact (and hence carry the most meaning) for them and which may need immediate attention. These ratings are also useful in comparing how the strength of later thoughts may change after you begin this work.

We encourage our clients to use the scale 0% (no belief in truth of thought) to 100% (completely true).



0% not true at all 10 20 30 40 **moderately true** 50 60 70 80 90 **100% completely true**

Back to the example in the workbook.

Jane's Unhelpful Thought Diary

Situation	Automatic Thoughts	Emotions/Feelings
Father soils himself before I am ready to leave. My paid caregiver has not arrived yet.	**1. He would have to do this NOW, he's doing it on purpose. 10%** **2. Why Me? 55%** **3. She (the paid caregiver) is not coming! 80%** **4. I NEVER get to do things for myself. 95%**	**frustrated** **angry** **hopeless**

As Jane rates the strength of each of her thoughts, we learn which thoughts are more troublesome to her and may require immediate attention. For example, her belief that she never has a chance to find time for herself ranks the highest at 95%. This rating is an important one to remember because as

Jane participates in psychotherapy, one way for her to measure improvement is by periodically re-rating the strength of this belief.

THE STRENGTH OF EMOTIONS

Likewise, it is important for clients to measure the strength of their emotional consequences as they record the situation. The range of the rating scale is the same, 0% means that the emotion is not at all present and 100% means that the emotion is completely present, or as strong as it could possibly be.

We can gain similar information regarding which emotions are the strongest, and we can also compare initial ratings to the later emotions that your clients will experience as their thoughts change. Once again, Jane's example demonstrated that she rates her emotions of frustration, anger, and hopelessness equivalently with hopelessness ranked as the strongest emotion.

Jane's Unhelpful Thought Diary

Situation	Automatic Thoughts	Emotions/Feelings
Father soils himself before I am ready to leave. My paid caregiver has not arrived yet.	**1. He would have to do this NOW, he's doing it on purpose. 10%** **2. Why Me? 55%** **3. She (the paid caregiver) is not coming! 80%** **4. I NEVER get to do things for myself. 95%**	**frustrated - 95%** **angry - 90%** **hopeless - 100%**

Identifying the Unhelpful Thought Patterns

As clients begin to identify and examine the unhelpful thoughts they have, they will begin to notice specific patterns (N.B. habitual themes usually indicate the presence of an underlying dysfunctional belief system) in both the types of thoughts and the situations that are difficult for them. We may even go as far as to say that clients will recognize a particular manner or style to the way they interpret stressful situations. Consider, for example, what happens when you are listening to a radio station with a head set (see illustration). The station, or signal, will come in clearly if the head set itself is clear, if it is correctly connected to the radio receiver, and positioned securely on your head. If the head set is not used properly, then you may mis-hear or mis-interpret the signal or information from the radio.

The same is true for the way we interpret situations around us and conversations that we have with others. Our interpretation of these events also happens through a kind of personal head set, or a set of thoughts that we use to make sense of our world. When we are depressed, our head set is tuned to a negative signal that interprets situations (whether stressful or not) in a negative way. For example, Jane's depression prompted her to view her father's behavior as a personal attack on her. Therefore, she maintains a negative head set, interpreting her experiences with unhelpful thoughts. If she were not depressed she may be able to more easily attribute her father's behavior to his own difficulties, taking it less personally.

A negative head set can be demonstrated through different patterns, or styles of thinking, and any one person can be employing several different styles at any one time. We have compiled a master list of negative thought patterns that are common among depressed, older adults. We suggest that clients mark these pages for easy reference as they begin to identify the kinds of thought patterns they use. People often find that some of these thoughts fit them better than others. You can educate your client to recognise their particular types of cognitive errors they engage in habitually. In many instances the judicious use of humour can help your client to recognise the errors they are making and not feel devalued by the process. Overleaf are a list of types of cognitive errors. You may wish to photocopy this page and give it to your client as a homework task to tick-off the errors they recognise. This sets up a monitoring process in itself and generates expectations in your client as to their participation in a learning process.

Initially of course your client may find it hard to identify what they were thinking when their mood changed. In this situation it is a good idea to use guided discovery. In this instance you should get your client to recreate the whole scenario around about the time their mood changed. Get your client to tell you exactly where they were and what they were doing. Who else was there, What time of day was it. Ask them to try to picture themselves in the situation and think back to the point at which they felt differently, at this stage in your conversation ask your client, "What thought went through your mind?"

HOT SPOTS IN THERAPY

Another point at which to help your client make the connection between their thoughts and feelings is to identify 'hot thoughts". This is where your client appears visibly upset during your session (often when talking about a meaningful event or stressor). If this happens during your session, you will probably want to identify the reasons for this change. You should say to your client, "Stop for a minute, you are looking upset right now, what thought went through your mind just then"? Socratic questioning should be used gently in this situation to help you and your client reach a shared understanding.

Signals from Your Negative Head Set

NAME CALLING: You attach a negative label to yourself or to others you are engaging in a style of name calling. Often these statements have a blaming tone. For example, "I'm a loser," "I was a bad parent," or "My husband is an idiot."

OBLIGATIONS a.k.a. **"TYRANNY OF THE SHOULDS:"** This type of thinking refers to the rules you have about the way you think things should be. These rules are often unrealistic expectations that result in strong feelings of guilt or anxiety when not met. For example, "I have to have a clean house before I can do anything fun."

DISCOUNTING THE POSITIVE: You recognize only the negative aspects of the situation and ignore or discount the positive accomplishments. Consider this example: When something goes well rather than allowing yourself some praise you think "I could always do better"

BLACK & WHITE THINKING
You view things as "either-or" with no room for the options that fall in the middle. For example, "I'm either a success or a total failure," or "I never get things right, I am always messing up."

CATASTROPHISING: You have a tendency to blow events out of proportion or "make a mountain out of a molehill" when you don't have all the information. You also take the little information you have as truth without confirming its validity. This type of thinking occurs in 3 basic ways:

a. **Over-Generalization** You overinterpret situations drawing conclusions with only a few facts. For example, you are out in the town and a friend appears not to notice you, you think "they don't want to be seen with me".

b. **Personalization**: You assume that others have negative intentions towards or views of you. For example, if your psychologist calls to cancel your appointment you immediately assume that she is unhappy working with you and will probably want to discharge you.

c. **Emotional Thinking:** You use your feelings as the basis for the facts of the situations. For example, "I am angry with my children, therefore I am a bad mother."

WHAT'S THE USE? This pattern of thinking is common for people who believe that their thoughts or behaviors are not effective in changing their situation. The common consequences of this type of thinking are the beliefs that your difficulties are hopeless. This pattern can also intensify depressed mood and inactivity. For example, "Whenever I plan an outing for myself it never goes as planned, why try at all?"

DOOMSDAY THINKING: You engage in doomsday thinking when you convince yourself that the future looks hopeless and bad outcomes are inevitable. People who use this way of thinking are often called "eternal pessimists."

IF ONLY/ HINDSIGHT BIAS: This is the sort of thinking error that emerges after some mistake or unfortunate circumstance has occurred. Often people will say to themselves, "You should have known better". This is a particularly nasty style of thinking as it induces guilt and shame, resulting in a feeling that it is too embarrassing to discuss what you feel guilty about. Noticeably it can be very liberating taking the risk of discussing this. Much of the theme of this style of thinking is regret. Here, you spend time thinking of past events wishing that you had acted or said something differently.

GOOD BOSS/BAD BOSS: In this style of thinking you are very compassionate and supportive towards others, especially those people struggling with difficulties. Like a good boss at work, you recognise that people need encouragement and support to learn from any mistakes. Unfortunately you are not so kind or supportive to yourself, especially when you are faced with difficulties or if you feel you have made a mistake. Like a bad boss at work, its easy to identify all that has gone wrong and just like a bad boss when things go well you never appear to attach much importance to this and so things you do well go unnoticed.

BASELINE DISTORTION: This style of thinking can be seen in people who have experienced a medical condition that resulted in some disability. Often the person compares themselves in a unfavourable light pre- and post illness. This can result in demoralisation and hopelessness. A good example of this is where someone has experienced a stroke previously. Despite

having made a good recovery, they remain dissatisfied with extent of recovery and see themselves as inadequate and inferior. The key strategy here is to construct an adequate baseline, i.e. the person notes what they can do now compared with what they could do the day after the stroke, rather than the day before the stroke.

Identifying Unhelpful Thought Patterns

The workbook continues with the example of Jane to illustrate the unhelpful thought patterns she is using.

Jane's Unhelpful Thought Record

Situation	Automatic Thoughts	Emotions/Feelings
Father soils himself before I am ready to leave. This paid caregiver has not arrived yet.	**1. He would have to do this NOW, he's doing it on purpose. 10%** **Overgeneralisation** **2. Why Me? 55%** **Overgeneralising: personalizing** **3. She (the paid caregiver) is not coming! 80%** **Doomsday Thinking, Overgeneralising** **4. I NEVER get to do thing myself. 95%** **Black-white & Doomsday Thinking**	**frustrated - 95%** **angry - 90%** **hopeless - 100%**

With this additional information, Jane is able to identify which signals from her negative head set she is using. It appears from this exercise that Jane is prone to overgeneralising. The identification of the more common thought patterns can be very helpful in later exercises of challenging and replacing these unhelpful thoughts.

PRACTICING A DTR WITH YOUR CLIENT

Work within session with your client on a recent specific situation and encourage them to complete a DTR using the following steps.

1. Identify the distressing event. Where were you, who else was there?
2. Identify any thoughts. (use guided discovery and imagery)
3. Rate (from 0% to 100%) how strongly they believe in these thoughts.
4. Identify emotions. Write down in one word, e.g sad, angry, etc.
5. Rate (from 0% to 100%) how strongly they experienced these emotions.
6. Reread the list of Signals from Your Negative Head Set and help your client identify any they feel are applicable. Set as homework.

The next page contains a full-paged 3-column DTR/UTD for you to copy for use with your clients. Attached in the subsequent page is a companion sheet developed to be given to your client the first few times they are given the DTR to complete as homework. It is important to discuss with your clients the ease or difficulty they experienced completing the UTD. Remember if you do not immediately address your clients experiences with this exercise, you run the risk of them disregarding it and missing a very important step in changing their depression. Remind clients that the more they practice this exercise, the more automatic and easier it will become. **Pacing within therapy is crucial here, it is important <u>not</u> to jump into challenging these negative thoughts after the first or second UTD. At this point, the skill to master is to recognize that stressful events are fueled by negative thoughts, and learning to identify such thoughts as soon as they occur.**

Identifying Automatic Thoughts

Situation	*Automatic Thoughts*	*Feelings*
Where were you? What were you doing? Who else was there?	What thought went through your mind when your mood changed? What did you say to yourself?	What emotion did you feel (describe in one word) How bad would you rate your mood? (0-100%)

Please remember to bring this form with you for your next appointment. Thank you

PART II: CHALLENGING UNHELPFUL THOUGHTS

As your client practices identifying their negative head sets, the process of recognizing negative thoughts will become more automatic. Once clients become familiar with the types of unhelpful thought patterns they use, it is time to challenge the validity of these thoughts to determine if they can be replaced with more helpful thoughts. Most of the initial challenging of thoughts needs to be carried out within the therapy hour. Your client may find it useful to be given a copy of the following:

STEP 1: IDENTIFYING NEGATIVE AUTOMATIC THOUGHTS

A good way to identify negative automatic thoughts is to help your client notice when their mood changes for the worse. If you notice your client getting upset within your session, stop and ask your client "I notice you are looking upset, what thought went through your mind just then," or "What did you say to yourself, when your mood changed". Often at first, it is important to work with the client in identifying ways in which they can begin to become aware of their thoughts. If you ask your client to record their thoughts as a homework exercise, you need to remind them that they are learning a new skill and so they may need to practice this technique (see below).

Good questions to encourage your client to use in trying to identify their unhelpful thoughts are:

When I noticed a change in my moods, what thought went through my mind?

What was about the situation (specify) that made it so important to me?

What does this situation mean to me? What was it about the situation that was so meaningful?

Remind your client that looking for rational answers to negative thoughts is not easy You can encourage you client to realise that with practice and perseverance it will get easier. Be honest with you client and acknowledge that standing back, and questioning our thoughts is not something we normally do, and we all tend to believe that our thoughts and interpretations are correct. Therefore, it demands an effort to consider alternatives and to change our minds.

Get your client to write down their thoughts just as they thought-it. For example instead of writing "*Thought about my marriage break-up*" get them to write it as they thought it, e.g. *"If my wife leaves me I'll might as well*

give up". Again you will need to provide some perspective here and acknowledge that at first it will be particularly difficult for your client to find rational alternatives when they are feeling upset. They may find it helpful at these times to only write down a brief description of the situation and then to distract themselves until they are feeling calmer. At this point they may be more able to return to what they have recorded and look for answers.

STEP: II: CHALLENGE AND FINE TUNE YOUR HEAD SET.

The following list is a set of techniques to help your client challenge their negative thought patterns and create a clearer head set. Some require them to perform actual behaviors in challenging their thoughts and others ask them to analyze their thoughts from a different perspective. Consider the following example

Alice is a depressed, 64 year old woman who is caring for her infirmed, 90 year old mother. She believes that she is an inadequate caregiver because she feels guilty when she wants to visit with her friends. Alice believes, "I should always stay home with my mother because something bad will happen to her when I leave. Other people can't take care of her the way I do. If something does happen everyone will know that I am a bad daughter."

POLLING: Many people engage in specific behaviors to obtain additional information in challenging unhelpful assumptions about situations or people. You might wish to encourage your client to ask friends for their thoughts about certain situations they might have had experience with. This technique is called 'Polling' and can be very useful as a way of evaluating the validity of thoughts. *For example, Alice could challenge her thoughts about being a "bad caregiver" by asking other caregivers how they handle time for themselves. Also, Alice could plan small outings to test out her concerns that her mother will have a crisis when she is gone.*

LABELLING - DEFINITIONS: Much of the negativity in your client's thoughts stems from the harsh language they use in talking to ourselves. They may often create labels for themselves or others without considering the true definitions of these words, or they believe that they must *always* behave, think, or feel according to some "rules" whose origins are unknown. Changing the actual language from negative to positive or from harsh to compassionate will replace a negative head set with a clearer one. *If Alice were to define her label of "bad caregiver," she will discover that she could not possibly fit that definition. She could also substitute "I should always stay with mother, " with "it would be better if I stayed, but others could help too," to begin to be less rigid with herself.*

NB When you are dealing with core beliefs and attitudes that are categorical, e.g. I am bad, you will probably not be aiming to get your client to endorse the opposite of this pole. You need to explore with your client what they would be comfortable with, e.g. I have my faults but I am ok.

ACT AS IF: When your client is talking to yourself in a harsh and negative way, consider changing your tone and language to talk to your self as if someone whose opinion you greatly respect is talking to you. *For example, as Alice blames herself for wanting to spend time away from home, she asks herself: how would my best friend Marie view this situation and what would she have to say about my predicament?*

CONSIDER ALTERNATIVES, IN-BETWEENS: When people think of only the extreme outcomes of situations, scores of alternatives get ignored. Think of a ruler that has 0 inches at one end and 12 inches at another-- there are many inches in between as well as even smaller and smaller measurements. *Could Alice consider other alternatives to <u>never</u> going out? Must she think of herself as a good caregiver **OR** a bad caregiver?*

SCALE TECHNIQUE: This technique is very helpful when your client is "stuck" on a particular thought or feeling. The scale technique is designed to weigh the advantages and the disadvantages of maintaining the thought (or emotion, or behavior). *What are the advantages of Alice believing that she cannot take time for herself? What are the disadvantages? Which side would carry the most weight? For example:*

ADVANTAGES	**DISADVANTAGES**
not feeling guilty	depression increased anger/ guilt/frustration isolation/ loss of friends poor health

What could Alice summarize from this exercise?

EXAMINE CONSEQUENCES: Work with your client to alert them to the fact that a consequence of maintaining their negative head set is depression. Deal with specific thoughts to link these to the specific consequences for your client. As youwork with your client to examine the specific consequences for each belief, you may find that they have less interest in maintaining it. *Alice maintains the belief that she must be the sole*

caregiver for her mother, which could lead to such consequences as exhaustion, tension, isolation etc. Why keep this belief?

CREDIT POSITIVES: Depression can skew the way people think. You might wish to set up a discussion with your client about 'mood-congruent bias'. This is the situation where depressed people find it easy to recall negative memories but have a greater difficulty in recalling pleasant ones. It will be easy for your client to forget that positive events, thoughts, or feelings do occur. Spend a few moments thinking of the more pleasant outcomes of events, positive thoughts you've had, and the positive emotional consequences that result. You may even think about setting a positive log as a homework task (positive log: your client lists all the good things that have happened over the course of a week). *For example, in what ways does Alice do a good job at caregiving?*

POSITIVE AFFIRMATIONS: Along with crediting the positive accomplishments and qualities that your client experiences, you may also want to develop some positive, personal statements that your client can say to themselves when they are feeling overwhelmed with negative thoughts and negative emotions. *For example, at times of distress, Alice could say to herself, "I deserve to want to spend time by myself or with friends, I am still a good caregiver."*

THOUGHT STOPPING/ SUBSTITUTION: This technique is helpful for people who find it hard to extinguish a particular negative thought. When your client finds themselves repeating the same thought over and over, get them to try shouting "STOP" to themselves out loud. You may wish to use this in conjunction with the 'rubber-band technique" where you client wears

a rubber band on their wrist and 'pings' it at the same time as they shout STOP! Then you need to replace it with a more helpful thought. *As Alice continues to think "I am a bad caregiver for wanting time alone," she could say, "STOP! I know I am a good caregiver, and I deserve to take care of myself."*

The Five-Column UTD

The Unhelpful Thought Diary that clients have been using up to this point has had 3 columns to catalogue the stressful event, the automatic, unhelpful thoughts, and the emotional consequences. As you and your client begin to challenge the unhelpful thoughts, the expanded version of the UTD is needed. This form contains the following information:

a.) a brief description of the stressful event

b.) Statement & rating of the automatic thoughts that occurred in the event

c.) Statement and rating of the emotions that were experienced as a result

d.) a list and rating of the more realistic thoughts to replace the unhelpful thoughts in column b

e.) a list and rating of the emotions (or new emotions that result)

In the client manual on page 46, the following example is presented:

Jane was able to immediately identify that her negative head set included themes of over-interpreting (both general and personalizing), doomsday thinking, and no in-betweens. She discussed with her therapist that she does have a tendency to take smaller details of a situation and blow them out of proportion. She was asked to consider several questions as a means to challenge these automatic thoughts that brought on such intense emotions as frustration, anger, and hopelessness:

1. **How does she know that the paid caregiver isn't coming?**
2. **What else could she attribute to her father's behavior?**
3. **Is it true that she NEVER gets to do anything for herself?**

Jane is also able to identify many of the negative consequences of her belief that her father is purposefully disrupting her day and that she must stay home with him. For example, this belief initiates a strong reaction of anger and frustration as well as causes her to cancel her personal plans. Thus, she becomes tired, more easily aggravated, and more depressed. Once Jane realizes the disadvantages to these thoughts, she becomes more willing to change them.

Work through a 5-column UTD

On page 48 on the client manual, clients are asked to complete a 5-column UTD using the steps below:

1. Identify the distressing event.
2. Identify the automatic thoughts.
3. Rate (from 0% to 100%) the strength of each belief.
4. Identify the emotions.
5. Rate (from 0% to 100%) the strength of each emotion.
6. Reread the list of Signals from Your Negative Head Set and indicate which ones were used.
7. Review the handouts, *Fine Tuning Your Signal: Changing the Way You Think* or *Twenty Questions* and ask yourself if your thoughts are realistic.
8. Replace the negative thoughts with more helpful responses and rate the strength (from 0 to 100%) of each of these new thoughts.
9. What are you emotions now? Re-rate the emotions experienced earlier and/or list new emotions.

It is quite common for people to have difficulty with the first 5-column UTD they complete. It is also true that even if clients were able to come up with helpful responses to their negative thoughts, they may not have a great deal of confidence in these new thoughts. It takes time for the newer, more helpful thoughts to "sink in." Also, it is helpful to remind clients that they are challenging thoughts that they have had for a very long time. At this point, it is more important that clients become aware that beliefs they thought would stay with them forever can be

changed; and the way that changes can be made is through practice, practice, practice! Encourage clients to get into the habit of completing a UTD each time they experience a stressful event. A good tip for the early stages of thought challenging is to give your clients the following as a handout. You might wish to review these for yourself and discuss this in-session

TWENTY QUESTIONS TO HELP YOU CHALLENGE YOUR NEGATIVE AUTOMATIC THOUGHTS

Is the way you are thinking helping you to find answers, or is it making you turn down possible solutions without even giving them a try? Below are listed 20 ways that people who are depressed or are anxious can use to help modify the way they think about things.

1. *Am I confusing a thought with a fact?* Just because you believe something to be true, does not necessarily mean that it is. Would your thought be accepted as correct by other people? Would it stand up in court, or would it be dismissed as circumstantial? What objective evidence do you have to back up your thought? What evidence do you have against your original thoughts?

2. *Am I jumping to conclusions?* This is the result of basing what you think on poor evidence. For instance, depressed people often believe that others are thinking critically about them. But nobody is a mind-reader. How do you know what someone else is thinking? You may be right, but don't jump to conclusions - it's safer to stick to what you know, and if you don't know, see if you can find out. How? Have you thought about asking people what they think?

3. *What alternatives are there?* Are you assuming your view of things is the only possible interpretation? How would you have thought about the situation before you were anxious or depressed? What evidence do you have to back these alternatives? How would another person look at it? How will you feel about it in a week's time? A month? A year, or even 5 years?

4. *What is the effect of thinking the way I do?* What do you want? What is the effect of your thinking on your life just now? Is the way you are thinking now helping you or hindering you? What would be the effect of looking at things less negatively?

5. *What are the advantages and disadvantages of thinking in this way*? Some thoughts might have some kind of usefulness - that is what keeps them going. But do the disadvantages outweigh the advantages in the long run. If so, can you think of a new way of looking at things that will give you the advantages, but avoid the disadvantages of the old way? Think of this as having an old plan that has outlived its usefulness and that you need to develop a new plan now.

6. *Am I asking questions that have no answer?* Brooding over questions that have no answer is unhelpful, for instances, questions like: How can I undo the past? Why does this always happen to me? Why is life so unfair? Brooding over questions like these is a guaranteed way to depress yourself. If you can turn them into answerable questions, so much the better. If not don't waste time or energy on them.

7. *Am I thinking in Black-and-White, all or nothing terms?* Nearly everything is relative. People, for instance, are not usually all good or all bad. They are a mixture of the two. Are you applying this kind of black-and-white thinking to yourself?

8. *Am I using global words in thinking?* Watch out for words like, always/never, everyone/no-one, everything/nothing. The chances are that the situation is actually less clear-cut than that. Mostly it's a case of sometimes, some people and some things.

9. *Am I condemning myself as a total person on the basis of a single event?* Depressed people often take difficulties to mean that they have lost all value as a person. Anxious people often take their difficulties to mean they are weak and can't cope. Do you make such blanket statements about yourself when something goes wrong? Is this fair do you think?

10. *Am I concentrating on my weaknesses and overlooking my strengths?* When people become depressed, they often overlook similar problems they handled successfully in the past and resources which would help them to overcome current difficulties. When people develop problems due to

anxiety, they often think of the problem as being of greater difficulty than they can cope with. Once people modify their way of thinking, they are often amazed at their ability to deal with problems. How have you coped with similar difficulties in the past? If you have faced similar difficulties in the past how did things turn out for you?

11. *Am I blaming myself for something that is not really my fault?* Sometimes people blame themselves for being depressed or anxious. They can become depressed about being depressed, or depressed about their anxiety problems. They put it down to a lack of will-power, or a weakness and criticise themselves for not 'pulling themselves together'. However, blaming yourself for something you see as a feature of your personality makes things seem unchangeable, if you see your current difficulties as being part of depression then you can deal with your symptoms.

12. *Am I taking something personally that has little or nothing to do with me?* When things go wrong, depressed people often believe that in some way this is directed at them personally, or caused by them , in fact it may have nothing to do with them.

13. *Am I expecting myself to be perfect?* It is simply not possible to get everything right all the time. Are you setting unreasonably high standards for yourself. What would you expect of others in a similar position? Accepting that you can't be perfect does not mean that you have to give up trying to do things well. It means that you can learn from your mistakes instead of being upset and paralyzed by your interpretations about the consequences of making a mistake.

14. *Am I guilty of double standards?* You may be expecting more of yourself than you would of another person. How would you react to someone else in your situation? Would you be so hard on them? You can afford to be as kind to yourself as you would be to someone else it won't lead to collapse.

15. *Am I paying attention only to the negative side of things?* Are you, for instance, focusing on everything that has gone wrong during the day and discounting or ignoring the things that have went well?

16. *Am I overestimating the chances of disaster?* Anxious or depressed people often believe that if things go at all wrong, disaster is sure to follow. How likely is it that if something doesn't go exactly as you expect it that it's going to be a major flop?

17. *Am I exaggerating the importance of events?* What difference does a particular event really make to your life? What will you make of it in a week, a year, 10 years? Will anyone else remember what you now see as a terrible thing? Will you? If you do, will you feel the same way about it? Probably not.

18. *Am I worrying about the way things ought to be, instead of accepting and dealing with them as they are?* Telling yourself life is unjust and people are awful does not make you feel better but only leaves you feeling more hopeless.

19. *Am I assuming I can do nothing to change my situation?* Pessimism about your chances of changing things again makes you feel hopeless and is not helpful to you. It makes you feel like giving up before you even start. You can't know that there is no solution to your problems until you try.

20. *Am I predicting the future instead of experimenting with it?* The fact that you have acted in a certain way in the past does not mean to say that you have to do so in the future. If you predict the future, instead of trying something different, you are cutting yourself off from the chance of change. Change is difficult and can seem frightening at times but it is not impossible if you take it step by step.

CHAPTER 5
Formulating Your Client's Difficulties

Formulation is one of the key skills in cognitive therapy.

Persons (1989) thinks of formulation as a hypothesis that a therapist develops about the psychological mechanisms underlying their client's current difficulties. Essentially, formulation is a way to understand the idiosyncratic nature of your client's difficulties.

Beck (1995) sees formulation as a way of 'seeing the larger picture' in terms of your client's history of their difficulties. *A formulation is a theory you develop about your client.* All good theories have two elements in common; they are **descriptive** and **predictive.** Formulations ought to share these two elements.

It ought to be able to account for your client's problems and their development.

It should be predictive: From your formulation you might be able to identify potential pitfalls in therapy. These are likely to be understood and foreseen from your formulation.

FORMULATION

Formulations serve a number of functions in cognitive therapy

To provide a deeper understanding of client -

- What early experiences contributed to current difficulties?
- What are the underlying beliefs/rules/standards/expectations?
- What coping strategies does client use to manage dysfunctional beliefs?
- What stressors (A/E) contributed to current presentation?

To guide interventions and improve treatment outcome

To guide the therapist in working towards effective homework tasks

To help predict and manage setbacks in therapy

To help the therapist work productively with the therapeutic relationship

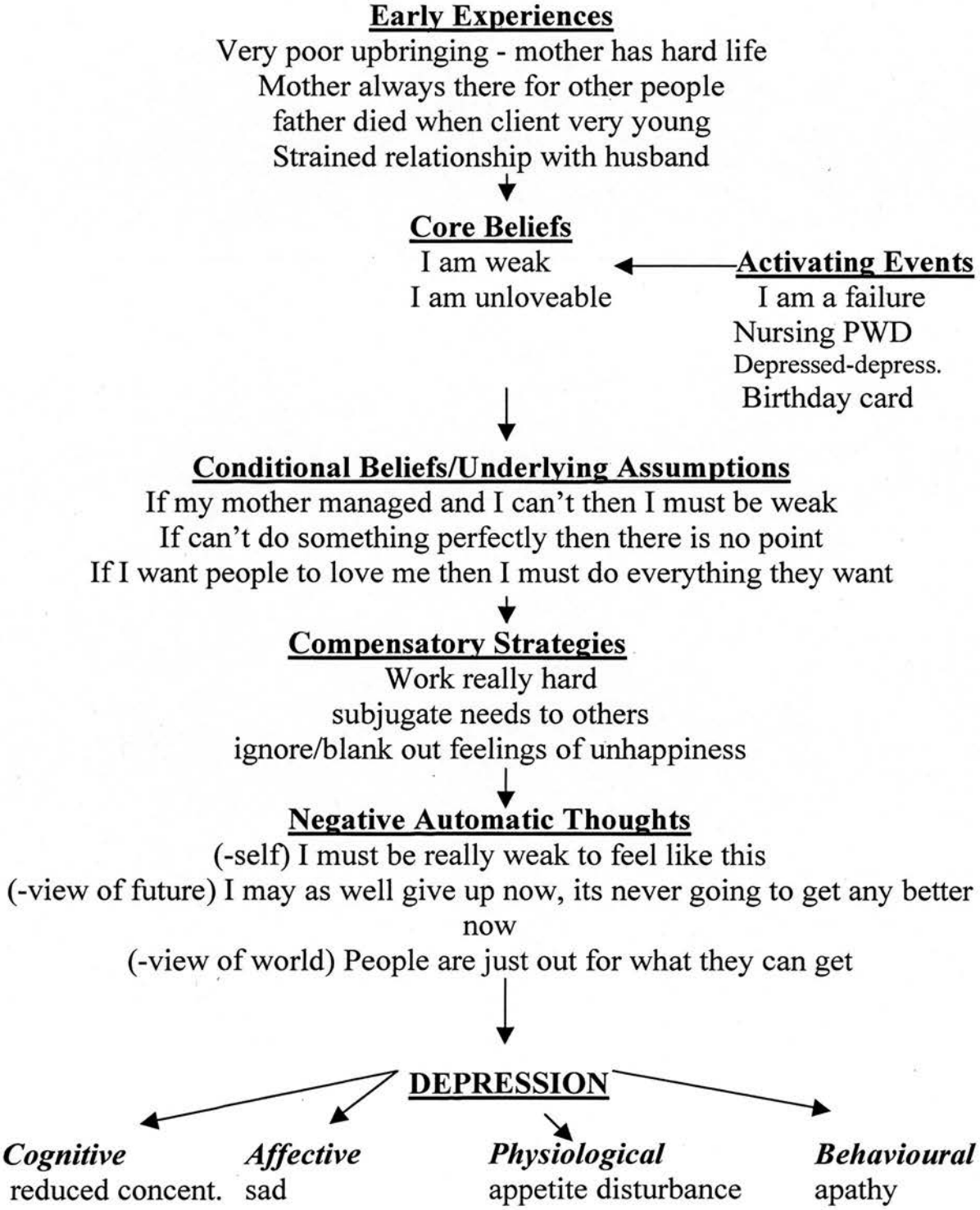
For example:

Mrs J. is a retired nursing assistant. She became depressed shortly after an incident in which she felt unable to manage things to the best of her ability (she demands 100 per cent all the time). As she became depressed she cut back on activities and cut herself off from friends. She started to become depressed about her depression, seeing herself as weak and a failure. She would often compare herself unfavourably to her deceased mother whom she often stated had experienced 'real hardships' in her life and had never become depressed. Mrs J, also had a disturbed relationship with her family and would often overcompensate for any difficulties in their relationships by

entirely subjugating her needs to them. She appeared to endorse the view that her needs were secondary to others' needs. This was evidenced by the fact that she would often 'loan' money to her great-neice, despite the fact that the money was never returned. Mrs J. would state 'her needs are greater than mine'

The following formulation (see below) was derived and discussed with Mrs J. It takes into account precipitating factors, predisposing factors and maintaining factors and is therefore descriptive of the nature of her current difficulties. Your formulation is also predictive in the sense that from the hypothesised conditional beliefs one might predict that she will characterise her difficulties as weakness and might therefore be less inclined to see these as unchangeable. She also sets high expectations for herself and her expectations regarding the extent of change and the pace of change in therapy needs to be explored. She is also very compliant and in therapy you might predict that she will find it difficult at first to take a full part in therapy, as she may go along with what the therapist suggests in terms topics in sessions. This might require you to ensure Mrs. J's active participation in therapy, in the early stage of therapy you may make this one of your goals for treatment.

In standard cognitive therapy as developed by Beck these ideas can be integrated together in a schematic form utilising the basic cognitive model for depression



Note in this formulation model that the bottom row (Cognitions, Emotions, behaviours, physiology) corresponds with your earlier introductory model in which you had used to understand your client initial difficulties. From Mrs J's negative automatic thoughts you can detect the three elements of the negative cognitive triad (negative view of self, world and future).

Also of note in this formulation is the delineation of compensatory strategies that your client uses to cope with their dysfunctional attitudes and core beliefs. You may set out to develop behavioural experiments to challenge the utility of Mrs J's compensatory strategies. The compensatory strategies ought to be considered as more malleable than core beliefs but less malleable than negative automatic thoughts and consideration needs to be given to the correct time to challenge these coping strategies.

DIFFERENTIATING BETWEEN OVERT & COVERT PROBLEMS

Within cognitive therapy, problems and difficulties are seen as existing at two levels -

OVERT AND **COVERT.**

Overt difficulties your client may present with could be phobias, depression anxiety or a combination of these. Overt difficulties are often the main reason a person seeks treatment.

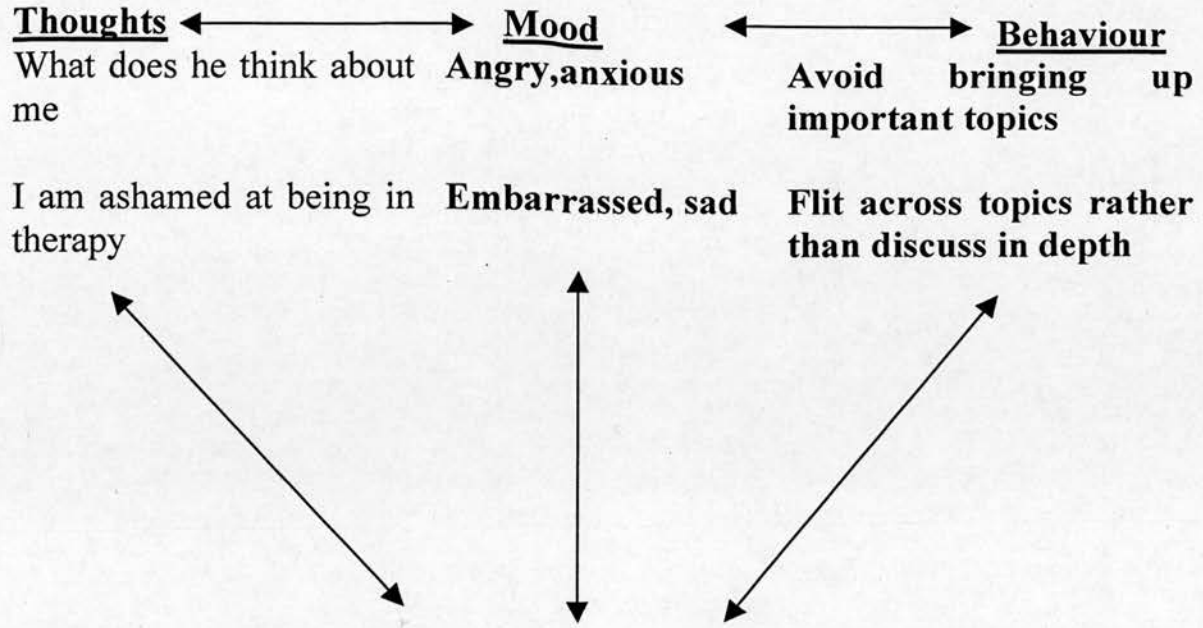
Covert difficulties are the underlying psychological mechanisms such as pre-existing vulnerabilities and maladaptive coping strategies that essentially maintain a person's difficulties. Covert difficulties in a formulation are the client's core beliefs, conditional beliefs and compensatory strategies. Covert difficulties interact with life events/stressors to cause and maintain a client's overt difficulties.

ALERTING YOUR CLIENT TO THEIR UNDERLYING PROBLEMS

You can alert your client to underlying problems by discussing general themes that appear to recur over a number of times within the therapy sessions. Alternatively, you may detect that certain thoughts and behaviours appear to occur again and again. This is a good opportunity to engage your client in a discussion of whether they are aware of this. You may also want to set up a socratic dialogue with your client to explore what might be the reasons for this repetition in themes, thoughts or behaviours. This intervention is particularly useful when things appear to be 'stuck' during your sessions. You may not be dealing at the negative automatic thought level but at the level of underlying beliefs and attitudes. This is good for

expanding your breadth of interventions with your client. It is also very encouraging for your client if you spend time within sessions modelling a problem solving approach to undertsanding your client's difficulties.

For example, Mrs. S. is a 68 year old retired civil servant. You have been working with her over the last five weeks and she appears to be experiencing a difficulty discussing any topics in depth. She appears to 'flit' between one topic to another within your therapy sessions. You are naturally concerned that your client is not allowing herself enough time to fully discuss problems to any degree of resolution. You set out to detect what underlying issues may be pertinent her by alerting your client to the presence of covert difficulties indicated by her overt difficulties. When you discuss your concerns with your client you are quickly able to bring out some underlying themes. Your client states she is concerned about what you think of her. There are a number of ways to deal with this. You could reassure your client about your respect for her but this does not address underlying issues here. When you discuss it within the session you draw out the overt-covert model and detect a dysfunctional belief. The outcome of the discussion revealed the following model:



I am weak and inadequate if I cannot sort out my own problems

As can be seen from the above, using this model highlights important issues to be addressed in therapy and it serves as a good introduction to the importance and relevance of the concept of underlying difficulties for understanding the nature of your client's difficulties. You can usefully explore the connection between their overt difficulties and underlying beliefs over a number of sessions. It is important that your client is able to work with you collaboratively in developing further links between their overt (or presenting problems) and their apparent underlying (covert) difficulties. A common mistake in formulation is to overwhelm your client with too much technical detail that your client finds irrelevant. Using the 'overt-covert' model can allow your client access to a fuller understanding of their difficulties. This model is a good stepping stone towards discussing a fuller formulation with your client in which you will take a developmental

perspective taking into account more background data. This can usefully be organised using the schematic of Beck's cognitive model.

Prior to discussing your formulation with your client you may wish to try to organise your thoughts by asking yourself a few questions:

Are there identifiable predispositions to the development of your client's current difficulties?

Are there identifiable precipitants to the development of your client's current difficulties?

Are there identifiable maintaining factors in your client's current difficulties? (note: these may be also compensatory strategies)

Before you develop your formulation further you may wish to take advantage of aspects of Persons' case formulation approach and complete the following formulation worksheet:

FORMULATION WORKSHEET

The Problem List (state in simple descriptive terms such as relationship difficulties, financial worries, insomnia, etc.)

1.....

2.....

3.....

4.....

5.....

6.....

The Working Hypothesis

Do you have a working hypothesis about the nature of your client's difficulties? Can you use your thoughts about predisposing, precipitating and maintaining factors to derive a sentence which explains how your client's difficulties have developed?

The Treatment Plan

Given your understandings and working hypothesis, what interventions do you feel are indicated. Do you anticipate any obstacles in the implementation of treatment interventions with your client?

Interventions:

Obstacles:

Once you have completed the formulation worksheet you may wish to use the following schematic as an organising structure which you could present to your client:

Early Experiences

Core Beliefs

I am.....

People are.....

The World is.....

Conditional Beliefs

If .....then.....

If..... then.....

Activating Events

Distal:

Proximal:

Compensatory Strategies

Negative Automatic Thoughts

DEPRESSION

Cognitive **Affective** **Behavioural** **Physical**

FREQUENTLY ASKED QUESTIONS ABOUT FORMULATIONS

At what point during therapy will I know when to introduce my formulation?

You should not feel pressurised into thinking there is a prescribed time for this. You need to be comfortable with your information before you proceed. The time for this varies due to a number circumstances such as the complexity of your client's presentation, your confidence and experience in developing a formulation and how quickly you feel you have developed a hypothesis about the nature of your client's difficulties. This hypothesis should takes into account the predispositions, precipitating and maintaining factors which are relevant here. You are probably ready to discuss your formulation when you can

(a) relate overt symptoms to some underlying dysfunctional belief

&

(b) put into a single sentence your understanding of the nature of your client's main difficulty.

In what way could I ensure that I am working collaboratively in presenting this information to my client?

It is very crucial that you take steps to ensure your client's participation in the formulation process. A useful tool in this regard is a flipchart. You might want to put some organising titles on the flipchart (such as important early experiences) and ask your client to fill in the blank spaces for you. You may

wish to complete the formulation in stages by specifying aspects of the formulation as homework for your client (e.g. ask them to note what types of negative automatic thoughts they commonly notice and what sense they make of this repetition). You need to avoid presently your formulation entirely verbally as your client may find this information overwhelming and off-putting.. Often therapists just talk about their formulation to their client and present a very technical 'lecture'. This is to be avoided by use of participation in multi-modal presentations within session.

How can I make sure my client does not feel criticised, or devalued by my formulation?

You need to ensure their active participation as stated above. You also need to constantly check that your client understands the relevance and importance of the task you and your client are engaging in. You can help your client to see this as a positive step away from their old ways of doing things. You can also help your client to identify any negative thoughts at the time and work on these before you client leaves your office.

Section III: Additional Skills

Chapter 6:

Using Relaxation to Treat Anxiety in Depression

Relaxation as an effective therapeutic procedure was first developed by Jacobsen in 1929. However, despite consistently demonstrating the utility of this method, Jacobsen's work made little impact. It was not until Wolpe incorporated a modified version into systematic desensitisation that relaxation received widespread recognition. Progressive Muscle Relaxation (PMR) involves becoming aware of the contrast between tension and relaxation of muscles. In addition when clients are told to 'relax', the therapist often modifies his voice accordingly by speaking in a softer tone, thereby introducing a degree of 'suggestion' into the technique

Relaxation can be an effective tool to break the vicious cycle of worrying and help your client feel more in control of their emotions. In cognitive therapy, relaxation is an important resource and can be viewed as an adjunct procedure - a means to an end. When introducing the concept of relaxation you ought to take a few moments to discuss any fears or misconceptions your client may have about relaxation. Emphasise to your client that relaxation is more than just 'unwinding' to music or taking their mind off things for a while. You will be teaching your client specific skills they may wish to use to help them ease anxiety and stress.

It is important to engage you client in a discussion of how they would know when they are anxious or angry. Do the same types of situations bring on these intense feelings? Many people report patterns of emotional reactions to

specific situations. Becoming aware of when these are experienced will help your client to take control of them.

Recognising the Physical Sensations Associated with Anxiety

We know when we are tense or angry because of our physical symptoms. Is there tension in our body? Does our head ache? Is our breathing too quick? These physical symptoms are typical signs of anxiety or anger. These physical symptoms are called "stress signals." Spend a few moments talking with your client about their stress signals of anxiety and frustration. You can also make use of a metaphor here.

> In homes nowadays, many people have fire alarms and these are sensitive to smoke, but smoke does not always mean fire and sometimes; for example when we burn toast, the alarm goes off. This can be annoying but we can judge when we ought to react to these alarms. Obviously, its good to have a smoke alarm even if it occasionally sounds when there is no danger. Likewise our bodies have an alarm built in; Stress and anxiety. In some people it goes off when there is no real danger. The trick is to judge when to react and when not to. By learning relaxation we can tune our alarms to become less sensitive to false alarms.

Explain to clients that alarm signals are the body's way of announcing that you must stop what you are doing to calm down and refocus your thoughts. When an alarm signal arises, it is time to introduce a "stop sign," which is a behaviour or a thought that will put the breaks on the negative feelings.

Some examples of "stop signs" are taking a deep breath, leaving the room, turning the lights off for a moment, or even a combination of all of these things.

Progressive Muscle Relaxation: Stages and Application

Your aim is to gradually take your client through a series of exercises designed to enable him/her to ***actively*** reduce their anxiety by relaxing. In order for PMR to be effective your client has to be taught how to recognise the early signs of anxiety and how to cope with the anxiety instead of letting it overwhelm them.

Progressive Muscle Relaxation:

The first stage helps the client relax using PMR. Your client is seated in a comfortable armchair and the therapist models how the different muscles groups should be tightened and then relaxed. The client does the tension and release exercises with the therapist and afterwards any questions the client may have are answered about the technique. Emphasis is on dealing with problem areas. The client is then given a tape of the therapist's voice (NOTE: IT IS RECOMMENDED THAT THERAPIST"S TAPE THEIR OWN VOICES DOING PMR TO GIVE TO THE CLIENT) and instructed to practise twice a day. **Note:** since your client is learning a new skill it is recommended that they practise relaxation when they are not feeling too anxious. The client is then shown how to fill in the record sheets. These last two requirements can form part of the homework exercises.

Release Only Relaxation

This phase of the exercise does away with the need for the tension part of the relaxation procedure. This reduces the time needed for your client to become relaxed.

Cue-Controlled Relaxation

An association is set up between the self-instruction 'relax' and the state of relaxation. The focus here is on breathing. The therapist gets the client to relax using the release-only method. Once this is done to the satisfaction of both parties, the therapist cues the client's breathing pattern using the words 'inhale', 'relax'. This method further reduces the time it takes for the person to become relaxed.

Differential Relaxation

This phase aims to make the skill 'portable'. Relaxation cannot be 'armchair-bound'. The client is taught to relax parts of their body not involved in movements such as writing while at a desk, or whilst standing, etc.

Rapid-Relaxation

This phase has two purposes, it reduces the time taken to become relaxed down to less than a minute and it allows one to become relaxed in more 'natural' situations. The client is asked to practise this about 10-12 times per day in order to perfect this skill. The client and therapist agree upon certain situations that will act as cues or prompts that the person must use to signal relaxation. Cues used included, as a passenger in a car, checking one's

watch, saving data on a computer disk, etc. The client is taught also to scan their body for any areas of tension

Application Training

A hierarchy of anxiety provoking items is constructed, items range from those provoking minimal anxiety to those anxiety provoking items the client themselves pinpoint as their personal targets. Items are worked through in order of severity. Exposure is carried out in application training and the client learns to respond with relaxation. The client learns they can cope with their anxiety and eventually dispense with it altogether. The therapist adopts the role of a 'sports-coach' and encourages the client to use their skills most effectively.

Identifying Anxiety & Tension

It is often very helpful to understand the sources of anxiety and types of danger signals experienced using a Tension Diary. The Tension Diary allows clients to record their most stressful times, least stressful times and their physical symptoms of tension.

Eduardo is a 69 year old Hispanic man who retired 1 year ago from a 40 year career in investment banking. He lives with his wife of 49 years in a home they have shared since they were first married.

Eduardo reports good relationships with his wife, his 5 adult children, and his 19 grandchildren. He started therapy to help him with the depression and anxiety he has experienced for the past 6 months since his mother moved into his home from Mexico after she had a stroke. Eduardo reported that he had just started several new hobbies (both alone and with his wife) to keep him active in retirement. Eduardo is the full time caregiver for his mother, since his wife stills works out of the home during the day. He specifically reported to the therapist that he feels tremendous tension in responding to these caregiving duties, yet he is the only one of his mother's children who can care for her. He explains that his one brother recently died of heart disease, and his one sister lives in Europe with her family.

Eduardo requests that his first goal be to reduce his tension and anxiety. The therapist asks him to complete a Tension Diary for the week. Eduardo's Tension Diary from Monday through Wednesday is illustrated:

EDUARDO'S TENSION DIARY

Directions: For each day, rate your average tension score. Indicate your least relaxed and most relaxed situations, as well as any physical symptoms that you experience.

Tension rating: 1 = Least tense you have ever been
10 = Most tense you have even been

	MONDAY	TUESDAY	WEDNESDAY
Average Score for the day	6	9	7
Most Tense Score	9	10	7
When & Where?	9:00 am breakfast	8:00pm living-room	1:00pm study
What was the situation?	wife was frustrated with my mother	on the phone with my broker	doing taxes
Physical Signs i.e. headache, stomache, restless sleep	head hurt back tense quick breathing	headache overall tension	quick breathing headache
Least Tense Score	2	5	4
When & Where?	12:00pm restaurant	2:00pm garden	3:00pm car
What was the situation?	golf with friend	reading paper, but thinking of discussion with broker and financial situation	running errands-but stuck in traffic

Eduardo does experience variations in tension throughout the day, which is very common. He notices that headaches appear each day as a physical sign of tension. This information has helped him recognize "danger signals," as well as begin to learn his/her patterns of stressful situations. In addition, Eduardo noticed that when he is engaged in a few pleasant events, his tension decreased significantly.

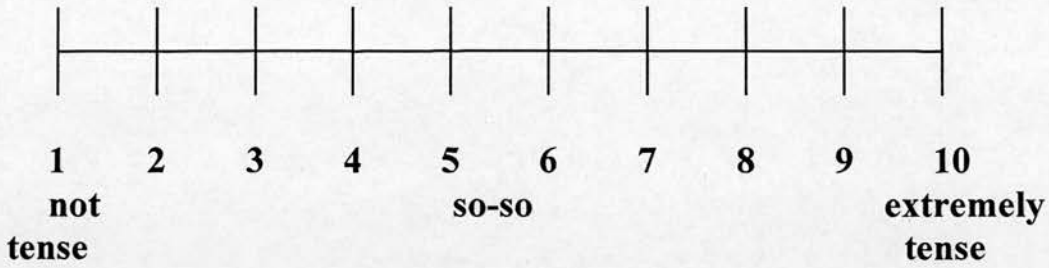
Practice the Tension Diary

On page 57 in the client manual, there is an opportunity for clients to become familiar with this form.

Caution Using Progressive Muscle Relaxation Exercise

There are many effective methods of relaxation, but you should be somewhat cautious in selecting an exercise for older adults. *For older adults with joint or muscular difficulties it can be quite difficult to engage in exercises requiring the physical tensing and releasing found in progressive muscle relaxation.* In these instances it is recommended that exercises focusing on visual imagery or concentrating on cue-controlled breathing can be used. In order for clients to gauge whether relaxation is helpful,

we suggest getting them in the habit of doing a pre and post tension rating using the scale overleaf (see also page 59 in the client manual).



Talk with clients about what has contributed to their anxiety/tension rating:

Why do I feel this way?

_____

_____

What danger signals am I experiencing now?

_____

_____

Relaxing using Diaphramatic (Cue Controlled) Breathing

This is a fairly simple technique to teach your client to use. It can be used either as an alternative or an adjunct to PMR. A typical introduction to breathing techniques is to make your client aware of the changes to the breathing when they become aroused and start to hyperventilate.

When people typically become anxious their breathing often becomes more rapid and shallow. During an anxiety attack a person's abdominal muscles tighten and constrict, thus interfering with the natural action of the diaphram. The person's chest often becomes tight and contributes to the fear that

anxiety can induce in your client. This can lead to hyperventilation and ultimately a panic attack.

1. Get your client to practise slowing their breathing rate by taking moderate breathes in and out. Get your client to lie on the floor or some other reasonably supportive surface (NOTE: Therapists may wish to model this technique in the session). It is useful to get your client to practise their breathing initially by placing their hand (or a small book) on their stomach and concentrating on noticing their stomach rising as they breathe in and falling as they breathe out.

2. Therapist's may wish to draw an outline of the way the diaphram muscle stretches and flattens to allow the lungs to expand (during the in-take breathe) and becomes curved to push the air out of the lungs (during the out-take breathe).

3. Encourage your client to gently breathe in and out at a moderate pace. Encourage your client to find their own pace. You can get your client to count their in and out breaths. Try getting your client to breathe in for three seconds and out for three seconds. Remind them to say the word *'Relax'* as they breathe out.

PRACTICING THE RELAXATION EXERCISES

Set Realistic Expectations

Often, clients expect their tension to decrease more than it does after their first few practices. Remind clients that the more relaxation is practiced, the more relaxed they will feel immediately following the exercise. Also, with

increased practice, there will be a decrease in the time it takes to reach a relaxed state. Some people report that their body and mind become completely relaxed by the first deep breath! Encourage the use of the Relaxation Practice Log to gauge progress.

Using Relaxation in Situations

Relaxation can also be used to prepare clients for an upcoming stressful event. For example, if visits to a particular family member are stressful, encourage clients to spend a few moments in their "relaxation spot" prior to the visit. In addition, many of our clients start the day with relaxation exercises, even if they are not in a high stress moment. The effects of relaxation can be a nice way to start the day, or create a calm break to refocus throughout the day. Many people report that music enhances the benefits of relaxation. Discuss this possibility with your client to create a diverse relaxation program.

RELAXATION: GENERAL PRINCIPLES:

1. Notice the "danger signals" and introduce a "stop sign!"
2. Sit in a comfortable place, keeping arms and legs uncrossed.
3. Keep eyes closed and block out all external sounds.
4. Breathe very slowly, inhaling through the nose and exhaling through the mouth. Focus on breathing with a steady pace throughout the entire exercise.
5. When imagining a safe place, let all thoughts floating into your awareness float out quickly. This time is meant as a ***break*** from the demands of life and ***NOT*** a time to focus on responsibilities.
6. Set aside times when relaxation is a treat. Remember: Practice enhances the effect!

RELAXATION PRACTICE LOG

Directions: Rate your level of tension from "1," least tense to "9," most tense before and after the relaxation exercise (circle the number that best applies). Record the time of day that you did the exercise and some comments regarding the prior stressful situation and whether the relaxation helped you. Do this each day.

DATE	TIME	RELAXATION SCORE	COMMENTS
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	
		Before: 1 2 3 4 5 6 7 8 9 **After: 1 2 3 4 5 6 7 8 9**	

Chapter 7.
Managing Anxiety, Worry & Insomnia

Anxiety is relatively common in later life. Some authors suggest that anxiety presents more commonly than depression. It is therefore, reasonable to expect that when you are dealing with your client's depression, anxiety will be a significant comorbid feature. In many more cases than not, your client will experience significant distress due to the presence of anxiety and worry.

Anxiety, worry and insomnia can often accompany depression. Many people report that increased anxiety can worsen negative thoughts, create significant physical tension and intensify any physical pain they are experiencing. We often hear people describe themselves as feeling "overwhelmed" by these emotions, unable to find a way to reduce their impact. It is also common for these feelings to be so intense that people find it hard to imagine a time when they were absent.

Another important feature in the clinical presentation of depression in later life is insomnia and your client's perception of impaired sleep quality and quantity. This chapter addresses these issues and presents a practical guide to managing these difficulties within a cognitive-behavioural framework.

Managing Worry

Cognitive-behavioral therapy clearly emphasizes attending to how clients are thinking, but excessive thinking about feared events or imagined impending catastrophies can lead to another problem; **Worry.** Sometimes people can't put some thoughts, especially worries, out of their minds. In your work, you may find that some thoughts stay with some clients longer or they will not respond to the kinds of skills that they have already mastered. The client manual presents the following example:

> **Geri is a 67 year old woman who is caring for her 76 year old husband with Alzheimer's Disease. She is currently doing well in a program of cognitive-behavioral therapy, but she finds that there are certain thoughts that stay with her longer than she would like. For example, after a tiring day of taking care of her husband's personal needs, Geri often starts a process of over-thinking, or excessive worry, where her beliefs & concerns seem hopeless. Geri often thinks "There's nothing I can do about getting my house cleaned, what will I do? What if I become ill, what will happen to my husband?"**

The signs of worrying: 'What If...' thoughts.

One sign of over thinking or "worrying" occurs when a thought or a set of thoughts stay around without any clear solution. You can educate your client to look out for 'worry-thoughts' such as "What if..." type questions. Worrying involves "stuck" thoughts that increase anxiety or sadness. Worry leads to rumination and while sometimes a solution arises, this is exceedingly rare. Often your clients say to themselves that they should stop worrying but this is often a hard thing to do unless they use certain strategies. An important first strategy is to teach your client relaxation. You

should re-visit chapter 6 if you have not already worked on this with your client.

In addition to relaxation there are important cognitive techniques that will help your client keep their thoughts in perspective. Mainly these techniques use education, verbal reattribution and behavioural experiments. Worry is a mental activity, so it can be useful for therapist's to help their client distinguish between the content and process of worry. The content of worrying thoughts may be amenable to testing in a similar fashion to identifying and modifying negative automatic thoughts in depression, but focusing on content alone is often unsatisfactory. In the process of worrying, one thought tends to lead in to another. For the therapist when dealing solely with the content of worries it can feel like trying to pluck a fish out a stream by hand; you almost get it and it appears to slip out of your grasp at the last minute. After many fruitless attempts at fishing this way and many near misses you can end up feeling defeated and dejected. In dealing with worry, time needs to be spend in the therapy session discussing the whole sequence of worrying and how this process can quickly escalate out of all proportion. It is useful for therapists to help their client make links between not just the content of worrying thoughts but the escalation of distress.

Worry and Vulnerability

Adrian Wells distinguishes between what is termed Type 1 worries and Type 2 worries: Type 2 worry is also known as *meta-worry*

Type 1 worry: Worry about everyday events, e.g. concern over family member, concern about ability to cope in situations

Type 2 worry: Essentially worry about worry, e.g. I am going to go crazy, I can't control myself, I'm losing it (mind)

You may find it useful to discuss this idea with your client and identify which type of worries they find most distressing.

Keeping Worries In Perspective: Fears about *Not* Worrying

You might want to explore your client's fears about worrying, particularly they may have fears that if they don't worry about something this will leave them vulnerable and unprepared. A useful technique here is to ask your client to think back to the past, Have they been in this or a similar situation before? How did that turn out? You might find it useful discussing some research that was carried out by Tom Borkovec in Philadelphia a few years ago. He got 100 people to write down their worries and he worked out how often their fears came true. In ***95 per cent*** of cases the situation or event the person worried about did not happen. You might wish to pause and discuss this with your client before letting them know about the rest of the research findings. In the ***5 per cent*** of cases where people's fears were realized, in 100 per cent of these cases, people coped much better than they would have predicted **AND in no instances did worrying about the event help them deal with the situation more effectively.** You should spend some time discussing what sense you client makes of this research. Can they relate to it, are there any similarities to their own experience?

Keeping Worries In Perspective: Thought Stopping

This technique involves actively halting "the worries" and moving to thoughts about other things. One strategy to teach clients is that once they recognize that they are worrying, they should try to say "Stop!" out loud. This may feel very unusual at first but it can be very effective. You can suggest to clients to practice saying (to themselves or out loud) "I am thinking about (the worry) right now, instead I want to think about (new thought)." This new thought should be repeated several times or work it out with a UTD. Eventually your client can say stop inside their head!

For example, if Geri was "worrying" about her husband's laundry when she needed to take time for herself, she might say "Stop! I am worrying about my husband's laundry right now. Instead I want to think about my grandson's birthday gift. He said he wanted a baseball glove." On page 90 in the client manual clients are presented with a table to generate situations that cause over thinking.

Suggested Exercise

1. Have clients pick one situation/topic and start to think about it and yell out "STOP!" after about 10 seconds. Clients often report feeling startled, yet this feeling can redirect their attention in order to either concentrate on this matter in a different way, or think about something else entirely.

2. Take that "worry" thought and try to write it out by attending to what you would rather be thinking about.

Stop! I am worrying about _____, but
I'd rather be thinking about_____

Encourage clients to repeat this statement several times to get a sense of what it feels like.

Keeping Worries In Perspective: Importance

One useful exercise is to ask your client to work out how important is the thing they are worrying about. You might ask them, "Will you still be worrying about this in 10 years time? Will you even remember it then? How many things in your life have you worried about that lasted 5-10 years or more?" "Will you be still worrying or bothering about this fear in a year from now? What about in a month's time?"

Keeping Worries In Perspective: Estimating Probability

Your client may be over-estimating the likelihood of their fears coming true. For example, David was a 67 year old retired sports-coach. He had a persistent fear that an ex-athlete he had fallen out with held a strong grudge against him. David felt certain that this person was sure to act on his grudge against him by getting his body-building son to 'visit' him. David held this fear of attack for a few years. This gave us the opportunity in therapy to work out the probability of his fears being realised. We were able to work out how many days he had held this fear (and hence the number of opportunities for attacks). There are different ways to calculate the opportunities for danger. David could calculate number of opportunities for the colleague's son to attack him on a *daily basis* over last two years; Hence 365 days in year x two = **720**, or alternatively David could work this out on

a *hourly basis*. If David works on a 10 hour day, then this figure is **7200** opportunities over the past two years in which he could have been attacked. Following this discussion, David was able to work out for himself that his fears were exaggerated. It is also useful to get your client to make predictions about upcoming events and compare their predictions with actuality. The therapist asks their client about any things they are worrying about over the coming week. If there is an identifiable fear, get your client to verbalise this specifically. Ask them to state their fears/worries explicitly in a single sentence. This is their prediction. Get them to rate their belief in the likelihood of its occurrence. Make it a condition of the homework that the client will record exactly how their feared situation turned out.

Another way to deal with probability of risk is to get your client to complete the following table to assess their risk:

RISK ASSESSMENT

What are you worrying about?

_____

Rate your anxiety about this event (0-100%)_____

Rate how convinced you are that the event you fear will come true (0-100%) _____

What is the worst that could happen if this did happen?

_____

If this did happen what thoughts might help you cope better?

_____

If this did happen what actions/behaviours might help you cope better?

_____

Re-Rate your anxiety about this event (0-100%)_____

Re-Rate how likely it is that your fear will come true (0-100%)_____

What is an alternative statement you can say to yourself now?

_____

Keeping Worries In Perspective: The Worry Half-Hour

Sometimes people feel better after they have worried about things a little. "Worry time" is a scheduled time during the day to focus worrying. Instruct clients to make a "worry list" and avoid thinking about them for the moment. Then, they could schedule some time every day to look at the list and really think about the worries on the list. It is important that clients *limit the time* to a specific amount, stick to this time limit, and plan something to do at the end of the worry time. We suggest that clients set a kitchen timer whose sound will mark the end of "worry time," and remind them to shift their attention.

For example, plan thirty minutes in the evening to worry right before a favorite television show. Look at the items on the list and think about each one, but stop as soon as your show starts. Many people find this technique helpful, although it may feel a little strange at first.

Keeping Worries In Perspective: Using Imagery

You can help your client conjure up images that allow them to let their worries go. This is a very simple procedure but some people are better able to use it than others. You can suggest to your client that they imagine all their worries as leaves on a tree in Autumn. Imagine the leaves (worries) one by one blowing away in the wind far off into the distance. Another image is for your client to think about imagining they have written all their worries on a sheet of paper and they place them in a time capsule and bury it in the middle of a field. Other imaginal exercises

include thinking of casting worries into the sea from a rowing boat, putting them in the fire and watching the paper they have written them on blacken and crumble. You can encourage your client to come up with their own images that they can alter. You may find this exercise works better when applied with some relaxation exercises.

Keeping Worries In Perspective: The Worry Decision Tree

This is a good strategy for dealing with persistent worries. This is a very focused way to get rid of worry. The procedure is outlined in a schematic that your client might find useful to take away and use out-with therapy sessions. It is a useful homework task when discussing worry.

When discussing worry you want to help your client feel more in control. They can do this by deciding whether or not they are able to identify the worry and whether they can deal with it or not. The first step is to ask your client to specify their fears, i.e. *"What is it you are worrying about?"* Next you ask your client, *"Is there anything you can do about this right now?"* If the answer is NO, you can remind your client they will gain nothing but distress by continuing to worry about this. If the answer is YES, You need to ask your client, "Is there anything you can do about this right now?" If your client is able, there is no point in delaying action as this only increases distress and decreases problem solving. If your client is not able to take action immediately, you can specify a plan of action and help them to use other worry control techniques in the meantime.

The Worry Decision Tree (after Butler & Hope, 1995)

What am I worrying about?

Is there anything I can do about this?

NO

Stop Worrying and distract yourself

YES

Work out what you can do, or, find out what to do, Make a list.

Is there anything I can do right now?

YES, I could...

.....

Do It Now &

stop worrying &distract yourself.

NO

Make a plan - until then:

Stop worrying & distract yourself

MANAGING INSOMNIA

Often co-existing with worry is insomnia. Sometimes worrying at night is the primary cause of sleepless nights for your client. If this is the case then help your client to get into practice of saying *"This is not the time for me to worry about this'*. Your client might find it easier to couple this strategy with pleasant image generation and relaxation. It is often helpful to work in session with your client to elaborate the pleasant image your client will use. Also you will wish to work out with your client the appropriate times they should practice generating and manipulating their image.

Insomnia is a very subjective experience. It is very common in many client groups, especially among older adults. Often people self-initiate treatment, generally using over the counter medications. The consensus appears to be that medications may be useful for short-term treatment of acute difficulties. The long-term efficacy of medication and their utility in the treatment of chronic insomnia is unclear. Research indicates that a number of problems may arise during longer-term treatment or discontinuation of treatment. These include:

- Alteration of sleep stages
- Daytime residual effects
- Changes in tolerance for medication and pharmacological dependence
- Rebound insomnia
- Age related metabolic changes

There are a number of non-pharmacological treatment alternatives for the management of insomnia. These are Education, Stimulus control therapy, Sleep hygiene, Sleep restriction, Relaxation, Cognitive therapy, Paradoxical

intention. You should check with your client to see if they use any medication, prescribed or otherwise.

Measuring Sleep Disturbance

There are general similarities to the type of information you require to monitor from your client regardless of their sleep difficulties and sleep management strategies (see ***Sleep Diary*** overleaf).

The sort of information you will seek to gain from your client is as follows:

Sleep Diary:

Day/Date							
Feelings at night e.g. tense, relaxed.							
Time of sleeps during day (if any)							
Time went to bed in evening							
No. of times you awoke during night							
Time(s) you awoke during the night. What did you do? Time you fell asleep again							
Time you awoke Rose from bed							

Obviously when gathering this information you will be asking your client to give as good an estimate of their sleep times as possible. Explain their perception of sleep disturbance is outlined by this information.

Education about Sleep Stages & Cognitive Therapy

Often your client will be concerned about the consequences of their perceived impaired sleep quality and quantity. Often this can set up a vicious cycle which maintains the probl

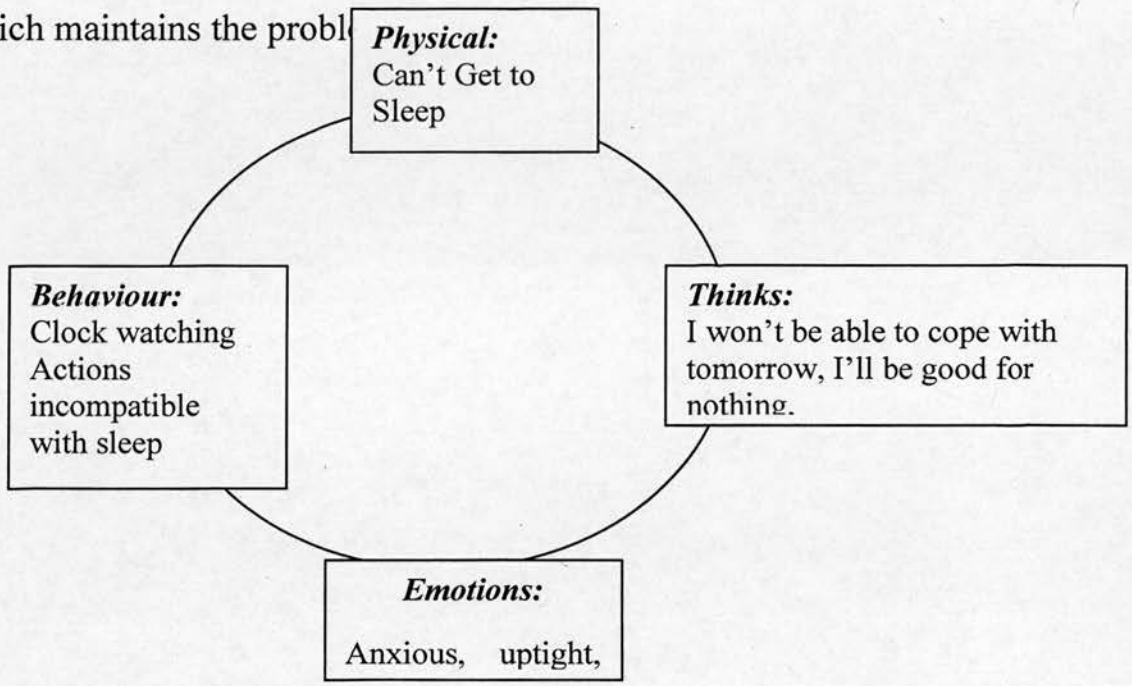


Figure 1: The sleep disturbance cycle

Following the initiation of this vicious circle, the person often develops anticipatory anxiety about sleep. They can often start to 'spectate' about their levels of sleepiness, which increases their anxiety and hence wakefulness. In these circumstances you might find it useful to engage your client in a discussion of their perception of the consequences to them of their sleep difficulties. Cognitive strategies of use here are 'cognitive control' such as pairing relaxation and image generation as described above. Cognitive restructuring is used to identify 'spactatoring' and to develop strategies to help person avoid this cognitive error. An important technique is to educate your client about the stages of sleep.

Stages of sleep

There are five main stages of sleep. You might wish to draw out on paper the cyclical nature of sleep across these stages during an average night's sleep. You can point out that stage 1 & 2 sleep is lighter sleep and indicate just drifting off to sleep. Stages 3 and 4 are deeper stages of sleep. These stages of sleep are considered the most restorative. In sleep deprivation studies, a person will normally conserve the most restorative sleep at the expense of the lighter stages. Many of your clients will know of this but it is good to elaborate on this. The fifth stage of sleep is known as REM (Rapid Eye Movement). It is during this stage that people dream. There are large variations normally in the time people spend in this stage of sleep. There is within person variation in this frequency too. The point of education here is to help 'normalise' your client's difficulties and make it appear less out of control.

Paradoxical intention.

Basically this technique encourages the client to do the opposite of what they have been trying to do in order to manage their difficulties. In sleep disturbance, you encourage your client to intentionally try to stay AWAKE. The basic rational behind this technique is that performance anxiety inhibits sleep onset.

Sleep Hygiene Techniques

This is where you look at your client's attempts at managing their sleep difficulties and attempt to identify if there are factors which might be changed in order to promote a better quality of sleep. Here you will be mainly concerned to explore health practices such as diet and exercise (i.e.

reducing intake of caffeine, increase exercise or activity level). You will also explore environmental factors such as light, temperature, and noise levels. Sleep hygiene procedures also make use of educative methods.

Stimulus Control Methods

One of the most overtly behavioural approaches to managing sleep disorders. The procedure consists of the use of instructional methods designed to enhance sleep compatible behaviours and reduce sleep incompatible behaviours.

Sleep Restriction Methods

One of the most overtly behavioural approaches to managing sleep disorders. This procedure consists of reducing the amount of time spent in bed. The procedure involves measuring how much time your client is spending in bed *sleeping*. This figure is compared to amount of time spent in bed (and not sleeping). For example, if you have a client who spends an average of 4 hours asleep out of an average 9-10 hours in bed, you seek your client approval to 'restrict' time spent in bed (from initial bedtime to time rising from bed in morning) to 4 hours. Your client gradually increases their time spent in bed by 15 minute intervals depending upon sleep efficiency. Sleep efficiency is calculated by dividing total time asleep by total time in bed. If this figure exceeds 90 per cent then your client should increase their time in bed by the prescribed time allowance. This is reduced if your client's sleep efficiency is less than 80 per cent.

Managing Sleep Disturbance

Often management of sleep disturbance utilizes a number of the above strategies. You may wish to photocopy the following as a sleep guide for your clients.

When you give your clients a handout on stimulus control and sleep hygiene methods, you need to emphasise that the procedures will not work immediately. You can reassure your clients that these are proven techniques that have an impact on sleep quality and quantity if persevered with. It may take a number of weeks for this to happen for your client. Remind them that medication does not help in the long term and may actually be counterproductive in their attempts at getting a good night's sleep.

Getting the Sleep You Need

Ask yourself, **Do I need as much sleep?** It is commonly known that as we get older we don't require as much sleep. If you go to bed later and rise earlier than you have been lately and your sleep improves you may have been trying too hard!

Avoid stimulants such as tea, coffee, cola drinks, alcohol and large meals late in the evening or just before you go to bed. Many people think alcohol helps sleep but the QUALITY of sleep is damaged by drinking.

Try not to cat-nap during the day. Many people are tempted to try to 'catch-up' on their lost sleep of the previous evening by napping during the day. This has the effect of making sleep harder to come by in the evening.

Stick to a bedtime routine. Rise in the morning at the same time regardless of how much sleep you had the night before. If your sleep has been poor, it may be tempting to lie in and get sleep, especially if you still feel tired. This has the effect of disrupting your sleeping routine and makes sleep harder to come by.

Try to unwind and relax before you go to bed. Ask your Psychologist for help with this if necessary. Also, **Only go to bed if you are feeling sleepy**. Don't read in bed or watch TV as this may be keeping your mind more active than it should be. Remember your bed is for sleeping in.

If you are still awake after 20-30 minutes, get up and go downstairs. Sit in a comfortable chair with the lights on low. You might want to read a relaxing story in a magazine. A milky drink may help. When you feel sleepy go to bed. If you still cannot sleep repeat as necessary.

Chapter 8.
Assertiveness and Anger Management

Speaking up for one's needs, or being assertive, can be very difficult when people feel depressed or anxious. In addition, Sometimes people who are depressed and anxious may not have the energy to talk to others about their needs, or they may not believe that they deserve to have their needs met. However, teaching your client to become more assertive requires them to try out a few straightforward skills.

THE COMMUNICATION CONTINUUM

Communicating with others requires learning about the different styles of communication that exist across a continuum. The central dimension of the continuum is the degree of respect you have in your own personal rights or the rights of others. This continuum has three key points: *passive, assertive*, or *aggressive* communication styles. See the following figure below:

Communicating Styles:

PASSIVE	**ASSERTIVE**	**AGGRESSIVE**
lose - win	win - win	win - lose

Below each label on this continuum is the description of the consequences of selecting that style. Being passive means that your personal rights are dismissed in favor of the rights of others. Being aggressive means that your personal rights are valued higher that those of others, who may ultimately feel dominated or humiliated by your communication. Communicating

assertively generally means that both parties feel satisfied and valued. We discuss these concepts more specifically below:

Passive Communication

In short, when we communicate passively, we are not expressing our feelings and our thoughts honestly. Communicating passively allows others to impinge on your client's rights; If your client speaks in an apologetic manner this results in others disregarding their statements. Passive communication also shows a lack of respect for other's abilities to handle problems. In general, the goal of passive communication is to please others while avoiding conflict. *For example:*

> **Jillian is caring for her husband who had a stroke 6 years ago. She is the sole caregiver for him even though she has two adult children that live nearby. Jillian was recently called by an old friend who is visiting from out of town. She made plans with this friend that required her to ask her daughter to stay with her husband for the afternoon. On the morning of these plans, Jillian's daughter called to say that she can't make it. Jillian told her daughter, *"That's okay, it wasn't very important anyway."* Jillian was not able to see her friend at all during her visit.**

In the client manual, on page 95, clients are asked to respond to this example by answering the following questions:

1. How does Jillian's response fail to show respect for her rights and possibly for her daughter's rights?
2. What might be some possible outcomes for Jillian? Consider what her thoughts and her feelings might be.
3. What kind of message do you think this gives Jillian's daughter?
4. Consider the last time you acted passively. What was the situation?
5. Now, take this situation and compete a UTD to learn about your thoughts and feelings regarding choosing to act passively.
6. Clients are asked to look over their UTD to determine the costs and benefits of passive communication.
7. What does this mean to you?

Aggressive Communication

Aggressive communication involves making statements that usually violate the rights of others. The goal of aggressive communication is to dominate others and forcing the other person into a "lose" position. It is basically telling people, "This is what I want, and what you want is not important."

Instead of Jillian telling her daughter that her plans are really not important after all, she declares, "I am so disappointed in you! You never help me with your father, and now I am stuck. Well, I don't accept your excuse!"

Again, on page 97, clients are asked the following questions:

1. How does Jillian's response fail to show respect for her daughter's rights?
2. What might be some possible outcomes for Jillian? Consider what her thoughts and her feelings might be.

3. What kind of message do you think this gives Jillian's daughter?

4. Consider the last time you acted aggressively. What was the situation?

5. Now, take this situation and compete a UTD to learn about your thoughts and feelings regarding choosing to act aggressively.

6. Look over your UTD, what might be some of the costs and benefits from choosing aggressive communication?

7. What does this mean to you?

Assertive Communication

In contrast to these two styles, communicating assertively involves expressing yourself clearly and honestly while considering both your personal rights as well as the rights of others. Assertive statements are expressed without humiliating, dominating or insulting the other person. Centre discussion with your client on the idea that assertive communication allows your client to care for others as much as it allows person to care for themselves.

When Jillian's daughter cancels on helping with her father, Jillian responds by stating, "It is very important to me that I get out of this house and visit with my friend. Let's find a way to work this out."

Once again clients are asked, on page 99:

1. How does Jillian's response show respect for her rights as well as her daughter's?
2. What might be some possible outcomes for Jillian? Consider what her thoughts and her feelings might be.
3. What kind of message do you think this gives Jillian's daughter?
4. Consider the last time you acted assertively. What was the situation?
5. Now, take this situation and compete a UTD to learn about your thoughts and feelings regarding choosing to assertively.
6. Look over your UTD, what might be some of the costs and benefits from choosing assertive communication:
7. What does this mean to you?

When to use assertive communication?

Encourage your client to consider the following steps in deciding to act assertively:

1. What is the goal or objective of their message?
2. How might alternative methods of communication help them reach their goal?
3. Pick the communication style that will most likely provide the best outcome. More often than not, assertiveness will be their best option.

Assertive communication:

THE BROKEN RECORD TECHNIQUE

Sometimes in assertive communication, negotiation is not possible. The broken record technique is a method where one, straightforward statement is repeated. This statement keeps the goal clearly in mind while being respectful of both the speaker's rights and the rights of others. This technique is particularly effective when you are dealing with obstinate people who may be pressuring you to do something you would rather avoid. This technique is also helpful in communicating with Alzheimer's patients or post-stroke patients who quickly forget information.

> One day Jillian makes plans with her friends on a day when her husband goes to an activity center. On the morning of Jillian's plans, her daughter calls and asks Jillian for help. Jillian clearly demonstrates her concern for her daughter's dilemma, but she is not willing to change her long awaited plans with her friends.

Jillian uses the broken record technique in her communication. Their conversation goes as follows:

Daughter: Mom, I need to get my car repaired, can Susan spend the afternoon with you?
Jillian: I have plans today, I will not be able to watch her.
Daughter: Where are you going? Maybe I can meet you? It's just for the afternoon.
Jillian: I'm sorry, I will not be able to do it. I have plans.
Daughter: Why not? I'm stuck.
Jillian: I can see that you are in a bind, but I have plans.

Review with clients (page 102):

1. What was the major point that Jillian conveyed?
2. What was Jillian's goal?
3. How did Jillian get her point across?

Summary of steps to Broken Record Technique

1. Stick to one point and don't get side-tracked.
2. Show respect for the other person. The goal statement can be preceded with a supportive comment.
3. Repeat the goal statement with minor modifications.
4. Avoid explanations for the chosen statement. This is not necessary. Explanations will introduce negotiation to the conversation. When this happens the focus of the goal is often lost.

Remember: If clients are having trouble initiating assertive behavior, encourage the use of a UTD to sort out their reactions.

ANGER MANAGEMENT

Many older people experience intense anger or frustration associated with their depression. For example, a great deal of work has been to help older people who are caring for an elderly relative or spouse with strategies to handle the many frustrating situations they experience. The steps involved in anger management are a consolidation of several different skills presented in this workbook, as well as work you may have already covered in therapy. Anger management makes use of relaxation which has been covered in chapter six of tis manual. The general skills used to help your client manage their anger include:

1. Recognizing the situations that result in an emotional reaction of anger.
2. Recognizing the danger signals (i.e. How does the body feel?).
3. Engaging in an activity to physically calm down, such as relaxation, breathing slowly, or even exercise.
4. Using thinking tools to identify and modify the automatic thoughts that lead to intense anger and frustration.
5. Using assertiveness skills (to be covered later) if needed.
6. Rewards for managing these feelings.

On page 63 of the client manual, the following example is presented:

Roberta is a caring for her husband of 40 years who has Alzheimer's Disease. She has recently paid someone to come to her home for several hours each day so she can run errands and do some visiting with friends. Whenever she gets ready to leave the house, her husband follows her around, walking closely behind her, repeatedly asking where she's going and when she will return. Roberta says that her husband's repeated questions are an extreme source of stress for her. She reports that at these times, her body tenses, her breathing is difficult, her head begins to hurt, and she is near tears. She handles the situation by screaming at her husband and leaving quickly, but then she says that "my whole day is ruined because I cannot shake this tension."

Follow Roberta through the steps outlined above to see if she can reduce her anger.

Step 1: What situations are the most stressful?

When my husband repeats questions over and over.

Step 2: Danger Signals: How do I know that I am angry?

I feel like I can't breathe, my head hurts, and all of my muscles feel like rocks. All I want to do is escape!

Step 3: How do I calm down my danger signals?

I know that I need to practice relaxation, but the only place I can do it is in th car before I go anywhere. Sometimes I hide in the bathroom to take a few relaxing breaths.
I would like to start a walking program again to get my muscles moving

Step 4: Changing my "angry head set": The Unhelpful Thought Diary.

Stressful Event	Automatic Thoughts	Emotions
My husband asks the same question over and over.	**I am trapped! - 95%** **He's trying to make me crazy. - 85%** **I can never stop this! - 95%**	**frustration!! - 100%**

Adaptive thoughts:

Getting upset will not help me.
He is not doing this on purpose, it is the disease.
I deserve to enjoy my time alone. I will just take a few breaths, leave the house and continue with my plans

Current Emotions:

Frustration - 50%
Some hope - 45%

Step 5: Reward for managing emotions.

I asked my helper to come for an extra hour at the end of this week so I can go to the movies with my friend Estelle.

Pages 66-67 of the client manual provides a step by step exercise in managing frustration.

Chapter 9.

Problem Solving

Previous chapters have discussed how unhelpful thought patterns lead to feelings of depression, anger, or anxiety. When clients are feeling overwhelmed by their difficulties, it is often hard for them to see potential solutions that will help change the situation into a more positive or hopeful one. This section presents a five step technique that will facilitate the development of more alternatives and options for managing a situation or solving a problem. The example from the self-help manual on page 90 is as follows.

Sally is a recent widow who recently started to attend a grief support group at the suggestion of her friend Louise. Louise provides Sally's transportation each week since Sally does not drive. This week, Louise told Sally that she could not take her. Sally ended the conversation feeling isolated and sad.

You might teach your client this well known acronym in order help them remember the steps in problem solving:

State The Problem (in specific terms)
Outline Goals and Aims (How does your client want their problem to change?)
List the Alternatives (What are the possible strategies?)
View the Possible Consequences (Pros and cons)
Evaluate the Outcome (Has it worked?)

Step 1: State/Define the problem

The first task is to state or define the problem ***as clearly and specifically as possible***. This step can often be the most challenging, as sometimes several different problems can be embedded into one. Clients need to sort out each problem and pick the one that appears to carry the greatest distress. *Sometimes it helps if you work with your client to try and state their problem in a single sentence.* Be sure to check with your client that the sentence you have constructed accurately covers their problem.

Sally defines her problems:
1. getting to the support group.
2. finding an alternative activity.
3. managing her feelings of loneliness and sadness.
Sally decides that she is quite committed to getting to the support group and feels more distressed about having no transportation than the other two problems listed.

Step 2: Outline Goals

Here you will be working with your client to set some goals for change. This is similar to earlier work you will have done with your client at the start of therapy where you and your client idenified problems and translated these into targets, i.e. how your client would like their problem to change. Sally came up with the following options to address the problem of getting to her support group:

1. **I can walk to the Senior Center.**
2. **I can ask a neighbor for a ride.**
3. **I can drive myself.**
4. **I can call taxi.**
5. **I can ask my daughter for a ride.**
6. **I can invite the support group to my house.**
7. **I can call a support group member and ask him/her for a ride.**
8. **I can decide not to go.**

Step 3: List possible solutions

This step allows possible solutions to be evaluated based on any criteria you want to use. Brainstorming is the key strategy used here where potential solutions to a problem are proposed. The key to brainstorming is NOT to evaluate each potential solution, but just allow suggestions to be presented. In brainstorming there are a number of rules which you should outline to your client beforehand. These are:

1. Don't evaluate any possible solution, the aim is to:
2. Come up with any solution, the more creative the better, and
3. Quantity is required in brainstorming, so that,
4. Ideas can be combined and improved upon.

Your client may evaluate whether they have time to devote to one solution or another, or they may evaluate each solution based on money, energy, or how much help they would need from other people, etc. As each item is examined some of the alternatives proposed may seem unrealistic, and therefore will get a lower rating than others. In rating the options, your client may assign ranks to them, or may choose to just use + or -'s to represent the evaluation. Sally's rating is as follows:

POSSIBLE SOLUTIONS	**RANK**
1. I can walk to the Senior Center.	**4**
2. I can ask a neighbor for a ride.	**1**
3. I can drive myself.	**7**
4. I can call a taxi.	**3**
5. I can ask my daughter for a ride.	**6**
6. I can invite the support group to my house.	**5**
7. I can call a support group member and ask him/her for a ride.	**2**
8. I can NOT go.	**8**

So, Sally's possible solutions, in order, look like this:

1. I can ask a neighbor for a ride.

2. I can call a support group member and ask him/her for a ride.

3. I can call a taxi.

You can see from Sally's rating that she believes that asking a neighbor for a ride is her #1 choice, followed by asking a fellow support group member, and then calling a taxi, and so on.

Step 4: Select one alternative and view the possible consequences

Clients should select the first alternative solution and see what develops.

After Sally decided that asking her neighbor for a ride was the best option, she called her and found out that her car was not working.

Your client can return to their list of options and select another possible solution and work it through.

When Sally could not find her list of support group members' phone numbers, she remembered that the Senior Center is just six blocks away, so she decided to walk.

In this step, the idea is to select the most promising option(s) and work out what is required in order for your client to put these solutions into action. It is important to identify pitfalls and obstacles (You may need to brainstorm solutions again here). A useful form to help your client view possible consequences of their identified solutions is printed below.

You might wish to photocopy this form to give to your clients.

Evaluating Consequences
My possible solution/strategy is:
In order to put my strategy in action I need to:

Step 5: Evaluate the outcome

This important last step can be very difficult for your client to complete. Ask your client, whether they are satisfied that the strategy they have decided upon has been beneficial. This departure from the old way of doing things can often present clients with new and unanticipated difficulties. You may have to take a problem solving approach to these.

Clients complete an example on their own

In the client self-help manual, Page 94 begins a step by step worksheet that instructs clients how to problem solve. These steps include:

Step 1: What was the problem? What did you need to solve?

Step 2: Brainstorm solutions. Remember, do not worry about the quality of each solution. Just write down whatever comes to mind:

Step 3: Evaluate and rank your choices. Start by picking out the most realistic, then the second, then the third, and so on.

What criteria are you going to use to rank order your choices?

Step 4: Choose an alternative.

What are you willing to try?

What happened?

What thoughts do you have about the way you solved your problem?

How are you feeling about your problem now?

Step 5: Choose another alternative, if needed.

What alternative are you willing to try now?

What happened?

What thoughts do you have about the way you solved your problem?

How are you feeling about your problem now?

Chapter 10.
Imagery

Imagery is another tool to manage intense feelings as a "picture" of the stressful situation and it's possible solutions are created in one's mind. The relaxation exercise from "Feeling Tools" demonstrated one type of imagery. Recall that we asked clients to select a safe place they could visit for a short while in their imagination. These same visualization skills can help challenge client's perceptions of the outcomes of stressful situations and manage intense emotions.

Identifying negative beliefs through imagery

The following presents steps towards using imagery to challenge negative beliefs. This is found on page 101 of the client manual.

- Think about a particular situation that produces intense, negative emotions. Briefly describe that event.

- **What emotions were present?**

- Now sit back, placing arms and legs in a comfortable position, and imagine the situation. Try to capture all of the components of the situation, the people, the sights, the sound, the colors, etc. Try to determine what was specifically problematic; isolate the *thoughts* that occur. Record those thoughts in the center column of a UTD.

- The intensity of the images often cause clients to "revisit" the upsetting situation. Encourage them to think of some calming images before continuing with the exercise.

Challenging negative beliefs through imagery

First...

Instruct clients to return to the stressful situation they just visited through imagery. Review the negative thoughts. Were any perceived outcomes catastrophized? Ask clients to rate how strongly they believe this outcome will occur (from 0 - 100%).

Next...

Instruct clients to return to the situation, this time picturing the outcome as they perceive it will happen. What does it look like? Ask for a description. Are the original perceptions likely? Ask clients to rate how strongly they believe in their original outcome at this moment (from 0 - 100%)?

Next...

Can they replace the unhelpful beliefs in column 2 of the UTD with more helpful ones (column 4)?

Next...

What about their emotions? Instruct clients to record any changes in their emotions considering their new perceptions (column 5).

Also...

Imagery can be useful in helping clients to prepare for a stressful event. For example, if a client becomes anxious or sad about a meeting with someone encourage use of the imagery exercise to practice and plan the kinds of things he/she would like to say. Imagery skills can come in handy when clients want to practice being assertive before they are placed in a "face to face" situation.

Section IV: Therapy Process Tools
Chapter 11: Reviewing Therapy Goals

Why review goals midway through therapy?

The mid-point of therapy is an important time to determine whether the treatment program is helpful to your client by evaluating the progress of their treatment goals. This process is also an opportunity for your client to consolidate the skills learned thus far and for them to make some decisions about the rest of the therapy. The following questions are covered:

1. How close are the goals met?
2. What parts of the goals are left to work on?
3. Are there any new goals to add?

Before you start goal review, we recommend that you ask the client to review their original goals. As you do this, let's go back to Mabel's first goal:

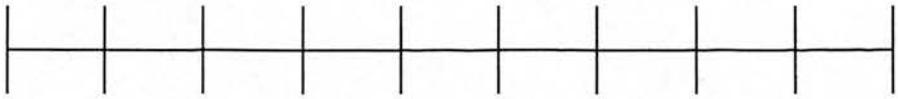
Mabel's first goal: To increase pleasant events in her day

During therapy, Mabel completed the Older Person's Pleasant Events Scale, and she constructed a list of pleasant activities that she wanted to introduce into her day. She found that some of the activities she was interested in included walking for exercise and relaxation, gardening, recontacting and visiting with old friends, and going to the movies.

Mabel completed a Daily Mood Rating Form and she kept track of her pleasant events each day. At first, Mabel found it very difficult to find 30 minutes for herself without believing that she was responsible for every one else's needs. Mabel's therapist encouraged her to complete UTDs addressing her negative thoughts regarding her rights to treat herself well. Mabel also engaged in several role play exercises which helped her practice assertiveness skills when she needed to tell others of her interest in spending time on her own activities.

By the midpoint of her therapy, Mabel was able to spend time in her garden each morning and take a walk every afternoon. She still had concerns about contacting old friends, explaining that she felt embarrassed about being so isolated during her depression.

In helping your client to review progress you might ask them to spend some time reflecting how much impact their difficulties have on their lives now. You may encourage them to review the severity of problems in this area now. Your client may find it helpful to use the key below:



1	2	3	4	5	6	7	8	9	10
not at all		**a little**			**very much**				**couldn't be worse**

With regard to specific issues and specific problems you might ask your client to consider how much improvement there has been in their problem areas since treatment began? The scale below may help your client frame this issue.

1 = Total improvement	**4 = Moderate improvement**
2= Very much improvement	**5 = A little improvement**
3 = Much improvement	**6 = No change**
	7 = Worse

It is useful if you can help your client to to focus on particular thoughts, events, behaviours or situations in which they can identify improvement using the scale above. For example, Mabel stated:

> **I now have time for myself each morning and afternoon. I am able to say "no" to my family when I would rather have the time for myself.** ***I feel I have made much improvement.***

N.B. Remind your client you are not seeking to 'win a popularity contest' but are trying to assess whether the treatment approach is proving beneficial to your client. In this regard you need your client to help you by answering as honestly as they can about the amount of progress they feel they are making. It is important for you to know if your client feels dissatisfied about amount of improvement or the pace of change experienced by them.

Next you can work with your client to identify how close they are to achieving their goal(s)? To focus on this issue and provoke discussion ask your client to circle the appropriate number. Using the scale below:

1 = Have achieved it	**3 = Moderately close**
2 = Very close	**4 = Fairly far**
	5 = Quite far

In reviewing progress towards goals with your client, it is important to consider if your client is still 'on-message' in the sense that this is still an active goal for them

Even when your client has maintained focus on their goal they may have developed some additional ideas about the nature of their difficulties through discussion within sessions. For instance if you have spent some time working on the OVERT-COVERT dimension of problems you may have developed ideas about how goals are linked. You may need to identify what else your client might like to achieve in regards to their goal(s)? For example Mabel stated:

I would like to be comfortable with recontacting friends I have not seen since my depression began.

Notice that Mabel still rates this goal as active. This means that she believes that this particular area, although currently improved, is still a challenge for her and will require attention both inside and outside of therapy.

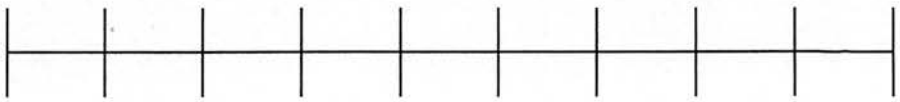
In reviewing therapy progress and discussing the notion of goal review you may wish to incorporate this within the agenda of one of your sessions midway through therapy. You may find this procedure to be helpful if you feel you are not making sufficient progress or if you feel 'stuck'. The following worksheet incorporates much of the elements of goal review and you might wish to ask your client to initially complete it as a homework task which you can discuss in therapy.

Goal Review

Goal review should involve reviewing each of your aims or goals, one at a time, You can discuss this information with your therapist.

1. What was your original goal?_____

2. How severe is your problem in this area now? Use the scale below:



1 2 3 4 5 6 7 8 9 10

not at all — a little — very much — couldn't be worse

3. How much improvement has there been in this problem area since your treatment began? Use the scale below:

1 = Total improvement
2 = Very much improvement
3 = Much improvement
4 = Moderate improvement
5 = A little improvement
6 = No change
7 = Worse

4. Please provide examples of the way you think things have changed for you using the scale above (e.g.1 = Total improvement, 7 = Worse)

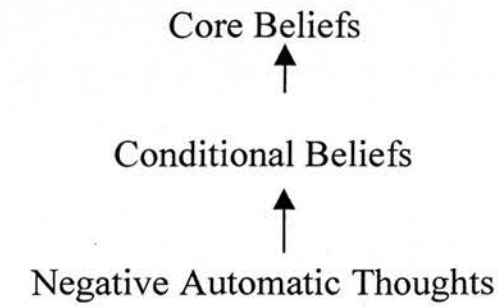
5. How close are you to achieving your goal? Please use the scale below:

1 = Have achieved it
2 = Very close
3 = Moderately close
4 = Fairly far
5 = Quite far

6. Is this still an active goal for you right now?

7. What else would you like to achieve?

therapist often has to derive hypotheses about the underlying (or covert) nature of the client's difficulties from their overt difficulties present often in the client's negative automatic thoughts. Themes can be inferred from the repetition contained within negative automatic thoughts, thus:



Identifying Core Beliefs from recurrent themes

Mrs W. has been referred because of chronic low mood over the last 2 years. She has a history of non-response to anti-depressant medication she describes her main problems as poor motivation, anhedonia, poor energy and impaired sleep. There is evidence of hopelessness as she does not see things being ever likely to improve. She has been avoiding social contact and prior to taking part in any activity she will think of the pros and cons before eventually opting to do nothing.

Over the course of treatment the therapist identified and raised the issue of her not following through with things. In discussion the common theme appeared to be *'Why bother, its never going to work out for me anyway'.*

The client was able to identify several instances in which she managed to get so far with tasks only to turn her attentions elsewhere. The following were examples of this:

- Taking medication for a short while and then stopping as it didn't have an immediate effect.
- Replacing curtain poles in house - identifying new type of pole, buying poles and then stopping
- Repairing golf- trolley; half completed
- Garden is half finished
- Not attending psychology appointments when knew needed to - getting so far and feeling the benefit and then stopping

The underlying theme was discussed and explored further using a technique known as the **Downward Arrow Technique**. Taking the example identified above, the reasons for the client's failure to carry through with task was explored as follows:

Downward Arrow Technique (DAT)

Situation: Get so far with tasks and fail to complete

Automatic Thought: Why bother it's never going to work out for me anyway

If this (auto. thought) were true what would this mean to you? In what way would this upset you?

response: I can't see the point in trying anymore

If this were true, what would this mean to you? What would be so upsetting about this?

response: I always used to see myself as strong & independent, now I'm a failure

If this were true, what would this mean to you? Would this be upsetting for you?

response: I suppose I see myself as weak now, I just keep expecting things to go wrong for me and I suppose I give up when I hit a hurdle.

From this interaction, the therapist has drawn out a ***recurrent theme*** from the client's actions and together they have ***identified an automatic thought.*** From this thought the therapist has engaged the client in a ***socratic dialogue***, in which the client becomes more aware of implicit messages she is giving herself. ***These implicit messages reflect covert or underlying dysfunctional beliefs*** about herself. A conditional belief could be stated as "If I cannot manage to do things by myself, then I am weak" The core belief that has possibly been uncovered is, "I am weak/ failure"

The next step is to question the client about the utility of these beliefs and assumptions. How helpful is this belief to them? What are the consequences

of holding this belief (particularly in difficult circumstances). It may be useful to distinguish between current circumstances now and times in the past when these beliefs (however maladaptive) may have served some function. You may wish to photocopy the DAT sheet (Overleaf) for you and your client to use when identifying core beliefs.

Other ways to Identify Dysfunctional Assumptions & Core Beliefs

In addition to inferring hypotheses about the nature of your client underlying assumptions and beliefs from the content of their thoughts, or by identifying recurrent actions you may identify these by using standardised measures such as the Dysfunctional Attitude Scale. This scale can be very useful in a number of ways; as a homework task, or as a qualiatative measure to stimulate discussion within therapy sessions. Other means of identifying covert beliefs is to provide your client with some statements and get them to complete these, for instance:

- I am...
- People are...
- The world is...

An alternative to this is to borrow a technique from Kelly's personal construct approach and ask your client to complete a 'script' as a homework task. You supply the following instructions to client's in order for them to provide a characterisation of themselves. This can be useful if your client finds it embarrassing or difficult to talk about certain perceived aspects of their self.

The Script:

Write a character sketch of (Client's name) just as if you were the main character in a play. Write it as it might be written by a friend who knows you very intimately and very sympathetically, perhaps better than anyone ever really could know you. Start by writing, (Name of Client) is:

If you use this technique with your client be sure to encourage your client to write in the third person.

Another way to identify beliefs and assumptions is to ask your client directly. This can be particularly useful when you notice your client appears to be struggling with particular aspects of a problem, e.g. "What does it mean to you that your daughter forgot your birthday?"

Finally, it is important that you are alert to the possibility of beliefs 'masquerading' as negative thoughts. This often happens when thoughts appear particularly resistent to cognitive restructuring, such as, "To be depressed is sinful", this often reflects a core belief, "I am a failure"

To summarise there are a number of ways to identify assumptions and beliefs:

- Ask person for their beliefs
- Infer beliefs from themes in thoughts and recurrent problems
- Use the downward arrow technique
- Use a standardised instrument such as the DAS
- Use sentence completion
- Use script characterisation

DAT Sheet

Situation:_____

_____

Thought:_____

Just for arguments sake, if this thought were true what would this mean to you? In what way would this be upsetting for you?

_____

If this were true what would this mean to you? In what way would this be upsetting for you? What would this say about you?

_____

If this were true what would this mean to you? In what way would this be upsetting for you? What would this say about you?

_____

If this were true what would this mean to you? In what way would this be upsetting for you? What would this say about you?

_____

Conclusions

I appear to believe that_____

The effect of holding this belief
is:_____

Modifying Dysfunctional Assumptions & Beliefs

The process of identification of assumptions and beliefs leads directly into modification. There are a number of techniques for achieving this. Importantly if you and your client decide to focus on core belief work in your sessions you need to identify your client's goals and aims with regard to this.

For instance, the person who holds the belief "I am bad", may not be comfortable with aiming for a change to "I am good", they may feel more comfortable with "I am ok, just like most people". Likewise when working with assumptions, you need to work with your client to specify what change they would be comfortable with. For instance, if your client held the belief, "If I don't do what others want then I am selfish" they would probably be uncomfortable with putting themselves first, always, therefore a more acceptable assumption might be "If I sometimes can't do things for others it doesn't mean I am a bad person". In any case you need to work with your client to find acceptable alternatives to their beliefs and assumptions. You may find it useful to revisit chapter two on the topic of setting targets with your client.

Cognitive Restructuring

There are a number of strategies for dealing with beliefs and assumptions which your client will be familiar with by this stage of treatment. You can make use of cognitive restructuring techniques such as asking ***'what's the evidence supporting your beliefs', and 'what's the evidence against this belief'***.

For example, Stuart is 68 years old and is retired. He retired on the grounds of ill-Health. He states *"Unless I am contributing to society then I am a drain on it"*. You might wish to ask Stuart to set up a chart assessing this, e.g.

Evidence for belief	**Evidence against belief**
I am just taking and not giving	I have contributed much over the years
I am past my usefulness	I am able to do voluntary work now
	I am viewing my worth as an individual solely in my work contribution. My family see my value as more than this.

Generally there are other issues that can be addressed with Stuart's assumption. It may occur to you that Stuart has developed a very negative view about ageing and you might want to discuss with him at a later date his views about older people's value and how this may have been influenced by societal attitudes to aging in our culture.

You can also ask your client to think about the ***effect*** of holding this belief. Additionally you may wish to do a **historical test of the origins of their beliefs** and assumptions.

Behavioural Experiments to test beliefs and assumptions

Once you and your client have clearly specified a main core belief you can set up experiments to evaluate their validity.

For example, You have a client who strongly holds the belief that most people do not like themselves. In your session you discuss this with your client and state that you do not agree and that you like yourself. Your client states that you are in a minority. How do you proceed? What can you agree upon as a homework task to take this discussion further?

The behavioural experiment that the client came up with was that they would ask friends (workmates) and family if they liked themselves (Polling technique). The client found a 100% response from people that they did like themselves. By doing this task, this client found an answer that was 'unexpected' and this forced them to see their belief as maladaptive. The experiment was set up collaboratively as both client and therapist were not able to predict exactly what would happen. *This was collaborative empiricism in action.* It was important in the follow up session that the meaning of this event was explored. It was also important to explore what

the client learned from this experience and how they might be able to use this in the future.

Other behavioural experiments explicitly require your client to confront their beliefs by acting in opposite ways, often this can be stated in a less threatening way to the client by getting them to act ***As if...***

In setting up behavioural experiments, you are asking your client to confront long held beliefs and assumptions, often these are difficult to change. It can be very productive to ***role-play*** scenarios prior to asking your client to try them out in situ.

Continuum Methods

The first step in this method is to identify clearly the core belief that is troubling your client. For example, if your client states "I'm bad to the core" you have something that you can work on. Before you attempt to help your client modify their belief, you need to have some measure of their strength of conviction about their belief. Thus you may ask your client to rate themselves on a continuum between badness and (?) goodness (you need to ask your client to help you specify the opposite end of the continuum).

X

0% 100%
Badness

However, if you use this continuum of their maladaptive belief as the focus for change this can be less helpful than if you had worked on the alternative or more adaptive continuum. For instance, if you get your client to move to the left of the continuum pole, you may get them to acknowledge they are 75% bad instead of a previous 95% bad. This may reflect a degree of change but essentially your client is still holding on to their belief in their 'badness'. A more useful way is to adopt methods developed by Christine Padesky and work with the adaptive belief after you have gained some measure of their strength of conviction.

Thus:

X

0% 100% Good

In using this technique you are basically trying to get your client to evaluate the validity of their belief and to help them introduce a degree of flexibility that was absent. Once you are working on the adaptive continuum you can ask your client to put marks where they would place friends and family on this pole. You can also ask them to mark where they would place people they admire. You can also ask them where they would place people they dislike. Continuum work can be developed over the course of a number of

sessions and may be mixed with other methods such as behavioural experiments and cognitive restructuring.

In order to take this method further, you can ask your client to give you their definition of 'badness'. You can get them to specify what they feel make up the components of badness in a person. You can then repeat the process of setting up continua that you evaluate with your client. For this client her component breakdown of badness was as follows:

X	
0%	100% Good
	X
Giving	Selfish
X	
Kind	nasty
	X
Calm and assured	angry & irritable

For this client, the therapist got them to give a definition of what badness meant to them and also to give a definition of the opposite; goodness. The therapist asked the client to mark where they saw themselves on each of the dimensions. Flexibility in belief was introduced by getting the client to compare themselves on each dimension with friends and family, people they

admire and people they dislike. Clients and therapists can use this method to introduce change and undermine strength of belief.

In addition, you can introduce another technique her which is called ***positive logging.*** For each of the adaptive dimension continua you ask your client to record instances of behaviour within their definitions. In therapy much emphasis is made on identifying negative behaviours as this is often the perceptual viewpoint of your client. In dealing with beliefs and assumptions it is very important to alert your client to the presence of evidence inconsistent with their beliefs.

The Prejudice Model

This last technique builds on work developed by Christine Padesky in California and by Melanie Fennell in Oxford. In essence you are introducing the notion that by holding certain maladaptive assumptions or core beliefs, you client is prejudiced against themselves.

Often people are strongly against any form of prejudice and a useful and provocative discussion of this can set the scene for your client. Introduce the topic by generally talking about how they feel when they hear that people are the victims of prejudice, i.e. in terms of opportunities being denied them.

You then may state, *"You know, sometimes I think you are prejudiced..., against yourself! Let me tell you what I mean..."*

You can introduce the core belief as prejudice. Once you have established your point and you have double-checked your client understands the analogy you are drawing you can proceed. You might find it helpful to talk about a particular type of prejudice and the consequences of this. For example, if someone holds the belief that all women drivers are bad drivers, they will tends to look for evidence that supports this view. You might wish to draw your client's attention to the idea that evidence to the contrary of a prejudice is often either discounted or distorted so that the prejudice is maintained even in the face of contradictory evidence. You can then take your client back to their belief, such as "I am bad" Have they discounted evidence which goes against this belief, have they modified or distorted evidence so that they continue to see themselves as bad? Have they thought of evidence against their belief in their badness as simply exceptions to the general rule?

To make this technique more effective you might use **socratic questioning** to ask them, "*What do you think, prejudice has to do with your difficulties,*

What is the reason, I am raising this issue with you" You can then introduce the connection between their beliefs and prejudice as above.

In summary, the following techniques may prove useful in modifying core beliefs and assumptions:

- Cognitive Restructuring

- Behavioural Experiments

- Continuum Methods

- The Prejudice Model

Section V: FINAL STAGE OF TREATMENT:
Treatment Termination
Chapter 13
Sessions 15 through 20 (approx.)

GOALS:

- Review what was learned
- Predict relapse
- Anticipate what to do
- Get closure on relationship issues

The final four to five sessions should be devoted to discussion about treatment termination and discussion about the maintenance of gains. This involves the same components which need to be incorporated into the basic structure of each session: a) set an agenda; b) review homework; c) select at least one topic to work on in depth; d) summarize; e) set up new homework assignment; and f) do mutual feedback

Scheduling the ending process

It is recommended that therapy end in a gradual and systematic way. The final few sessions could be "spaced out" (that is, they won't be held weekly, but perhaps biweekly, or monthly), in order for the client to begin to disengage from the therapeutic relationship and to independently use the tools learned in therapy to combat negative moods. We have found that more gradual terminations are easier for the client to adjust to, and are associated with more long term improvement. We also recommend, if

needed, the possibility of scheduling "Booster Sessions" after your last formal session. "Booster" sessions are designed as a "check-in" to see how the client is using these skills independently. We often schedule booster sessions to occur anywhere from 1 - 2 months after the official last session.

What does ending mean for your client?

During the final sessions, we encourage discussions with the client about (1) what ending therapy means, (2) the client's ideas about what was more helpful and what was less helpful during treatment, and (3) the client's feelings about the therapist as a person. Talking explicitly about these issues helps create a more positive ending, and will give the client a sense of closure that is very important. You can also encourage the client to complete UTDs related to his/her fears and concerns about ending therapy. Another topic that may come up at this point in time is whether or not the client should continue with another professional therapist, go on anti-depressant medication, or perhaps join a self-help group or a support group of some kind in order to stay in contact with other people who have had similar problems and gain support from them.* These are important issues that should be talked about frankly and thoroughly at this time. There are no general guidelines that are appropriate for all clients, but rather only individual people with individual needs.

* For clients participating in the Late Life Depression Study (Fife & Glasgow) You may need to discuss with your client what they would do in the next six months if they felt they were needing more support. You also remind them that they will be contacted shortly by a researcher at the end of treatment and 3 months and 6 months after this time.

Maintaining changes after therapy has ended: The Maintenance Guide

How were changes made?

The "MAINTENANCE GUIDE" is a specific document created by both you and the client that consolidates the client's experience in therapy to review skills and prepare for possible problems in the future. We recommend using three sessions to create this document before the final "goodbye" session. We recommend you start this guide in session and have your client complete, or add to it for homework. Also, for those who use UTD's well, it can be very helpful to have client review copies of actual UTDs completed during treatment to see what were some important issues in the beginning of therapy and what was the progression over time in his/her understanding of the problems and reduction of depression and other negative effects associated with the problem. You may want to give the client a set of blank DTRs for future use.

Review of skills

To begin with, ask your client to review the skills learned throughout therapy. On page 120, there is a review sheet to document cognitive, behavioral, and interpersonal skills. The client is asked:

HOW DID I MAKE CHANGES IN MY GOALS?

- **What were the cognitive skills I have learned?**
- **What were the behavioral skills I have learned?**
- **What were the interpersonal skills I have learned?**

Future Stressful Situations

Ask the client to think about and make a list of the situations that are likely to arise in the future that may exacerbate symptoms and result in depression. Ask your client:

What kinds of high risk situations might I experience that would send my thoughts and emotions into a downward spiral?

How will future stressful situations be handled?

Next, after the list is generated, ask your client to think of specific behavioral and cognitive skills (from the earlier list) that would help in each particular situation.

Recognizing DANGER SIGNALS

Encourage your client to talk about DANGER SIGNALS that should serve as warning signs that, despite their best efforts, low moods are again present and is getting more severe. Together, work out a plan of what to do and who to call, to help deal with the possibility that for some reason, the strategies learned in therapy do not seem adequate, and do not fully do the job of minimizing a depressive reaction. That sometimes happens, despite our best efforts. For example, people may become overwhelmed by one very big negative event (such as death of a loved one) or by a series of smaller but frequent negative events (several bad things happening at once, over-taxing your ability to cope). This can happen to anyone. It is important that clients think back to this most recent bout of depression and try to remember what their main symptoms were. Help your client make a list of the symptoms

that they would consider to be their DANGER SIGNALS. This way they can notice them right away and make immediate plans for constructive action.

What to do when a Danger Signal is experienced?

The final aspect is to develop a concrete plan or what to do when certain symptoms resurface. Who can the client call? What should he/she do if you are no longer in the area, or are not available, and he/she needs therapy again? You should have specific answers to these questions, so that you can terminate with your client in confidence.

The workbook is a resource.

All the notes, exercises, handouts, and thoughts regarding the work instruct the client to keep it in a place where it is easily found. Encourage the use of the workbook as a written record.

Chapter 14

Trouble shooting

or What to do when your client says....

Often in therapy there are a number of issues that challenge therapists. In many instances obstacles can be anticipated form your formulation or conceptualisation. However, there are also instances where despite applying techniques competently difficulties arise. Outlined below are a few known obstacles and a range of options is specified.

What to do when your Client says...

"I don't have any negative automatic thoughts"

Often in depression, it can appear to your client that their mood has changed for no apparent reason and they may not have been able to identify an automatic thought. You may find it useful to have your client specify images or pictures in their head just before their mood changed for the worse. If your client still experiences difficulty identifying a thought or image, you can use guided discovery to help them identify what they were doing exactly before their mood changed. You need to get your client to specify in as much detail as they can the circumstances in this instance. You ask your client if they can picture themselves back in the situation and recall their feelings. You use this as a basis for establishing mood changes. It may be

that your client has difficulty identifying 'causal' thoughts but is able to identify follow-up or maintaining negative thoughts, it may be productive to work on these thoughts initially.

It all seems so hopeless nothing is going to get better so why try...

If you have been trying cognitive restructuring techniques without success here, you may be dealing with a core belief masquerading as a negative automatic thought. Therefore go back to your formulation and work with your client to see if this makes more sense as a core belief. You may also wish to discuss the mood-congruent memory bias concept with your client. Essentially, when people feel depressed, they find it harder to recall pleasant memories, with selective recall for mood congruent memories. Thus, people find it harder to see things improving for themselves as they look back over a perceived catalogue of failures. Their memories are in fact coloured by their mood and may not be entirely accurate.

Your client complies but only minimally

Often therapist's experience difficulties in ensuring their client comply with therapeutic procedures. The part of therapy that carries the highest risk of non-compliance is homework completion. If this is the case you need to revisit chapter one's overview of collaborative homework setting. If your client is not complying despite being clearly understanding the rationale for aspects of your therapeutic work together, you need to raise this as an issue in therapy. Set this on the agenda for your next session and spend time exploring what it is that prevents your client from fully participating in therapy. Does your client have any fears or expectations about the outcome? Does your client fear that you will have less regard for them if they reveal themselves more openly. In these scenarios, you may need to open up a discussion about trust and risk. Perhaps your client needs to risk something in order for their old habits to change.

You don't like your client...

This can occur and can often come as a quite a shock to therapists who are used to being able to offer their clients positive unconditional regard. Often if you reflect on your feelings about your client you may be able to use this

productively to bring about change. You might wish to ask yourself when you first started to experience such feelings towards your client. Your client's behaviour in sessions may provide important clues to the way they relate to others out-with session time. You may want to raise this as an issue with your client. If you adopt a supportive stance on this issue this can promote important change for your client

Your client thinks all their problems are due to their age or they say, "You can't teach an old dog new tricks..."

This can be a common expression early on in therapy. You may wish to tackle this in a number of ways. First ask your client at what age did they stop learning things? You can use humour to point out the lack of reality in this global statement. You might also wish to an educational stance here and discuss with your client the broader societal pressure that seems to be evident in this statement.

Older people are often a devalued section of many industrialised societies. If we have accepted this idea earlier in life we still have it when we are older. In other societies it is recognised that age does not have to be seen negatively. You can also point out that research evidence shows that older people can be trained to improve their memory and are actually better at

remembering than untrained younger people. If your client thinks all their problems are due to their age ask them to compete a timeline and trace the antecedents of their current difficulties.

Alternatively, if your client has an age related illness, work with your client to assess what the main nature of their difficulties is. Is it due to the problem itself? Is it compounded by their age? (and, if so in what way?), or does the problem result in consequences which your client finds intolerable? If it is the latter, ask your client "would these difficulties have been easier to cope with at a younger age?" This is a fertile area for using socratic questions to really understand your client's perspective.

And don't forget ...

In addition to the importance of your client's factors, you bring into therapy your own thoughts, beliefs and attitudes. It is important to examine our thoughts and our beliefs as these may have the effect of limiting what can be achieved both within sessions and over the course of treatment. Christine Padesky suggests that the ultimate efficacy of cognitive therapy is enhanced or limited by the beliefs of the therapist practising cognitive therapy. It is arguable that skilled therapists who hold beliefs that cognitive interventions are potentially beneficial to the clients they come in contact with will be

more inclined to adopt a 'try it and see' approach. This approach arguably enhances rather than limits therapy options that potentially have an effect on outcome.

Ask yourself, what behaviours do you feel inhibited to express during your therapy work? (Christine Padesky suggests some examples such as; allowing silences, self-disclosure, etc). Make a list and reflect upon this.

1._____

2._____

3._____

Ask yourself, what behaviours do you express too much during your therapy work? (Padesky suggests some examples such as; giving lengthy explanations, Giving client the answers to socratic questions, etc). Make a list and reflect upon this.

1._____

2._____

3._____

Ask yourself, what emotions or expressions of emotion make you uncomfortable during your therapy work? (Padesky suggests some examples such as; client's anger, feeling irritated with your client, etc).

1._____

2._____

3._____

There may be other factors that we need to take into account when exploring these issues. Would your responses change depending upon the characteristics of your client? For example, does your clients' age, gender, and educational level influence your expectations for outcome? Can you think of examples of work with clients where this has been helpful and/or unhelpful. Use the space below to make notes.

1._____

2._____

3._____

4._____

Additional Reading for therapists

Beck, A.T., Rush, A. J., Shaw, B. F., & Emery, G. (1979) Cognitive therapy of depression. New York: Guilford Press

Beck, J.S. (1995) Cognitive therapy: Basics and beyond. New York: Guilford Press

Futterman, A., Thompson, L. W., Gallagher-Thompson, D., & Ferris, R. (1995). *Depression in later life: Epidemiology, assessment, etiology, and treatment* in Handbook of Depression, 2nd edition, edited by E. Edward Beckham & William R. Leber. New York: Guilford Press, pp. 494-525.

Greenberger, D. & Padesky, C. A. (1995) Mind over mood: A cognitive therapy treatment manual for clients. New York: Guilford Press

Lewinsohn, P.M., Munoz, R. F., Youngren, M.A., & Zeiss, A. M. (1986) Control your depression. New York: Prentice Hall

Persons, J. B. (1989) Cognitive therapy in Practice: A case formulation approach. New York: WH Norton

Rowe, J.W. & Kahn, R. L. (1998) Successful Ageing: The MacArthur Foundation study. New York: Pantheon Press

We are interested in your opinion...

What is your general opinion of the manual as a therapy guide?

What are the strengths of this manual?

What are the weaknesses of this manual?

What else would you like to see included? What is missing?

Tell us a bit about yourself...

What is your Speciality? How many years doing this?

Have you trained in cognitive therapy?

If so, where?

We would be very grateful if you would notify us of any errors, or omissions you may have identified. Please address all your comments to:

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